

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Their please remove containers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Frank L Alvaro</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 - 8 - 81</b>			2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 - 5 - 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>86</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy Reggio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel general</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tailor, retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MD Clothing Co.</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Cape St. Claire</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1152 St. Catherines Dr.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bruno Alvaro</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antonitte Degeorgio</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213-05-8455</b>		17. INFORMANT ADDRESS <b>Frances Alvaro 1052 Lido Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the prostate</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cancer of the Bladder</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>8/7</b> 19 <b>81</b> , to <b>8/8</b> 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>8/7</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.									
22b. SIGNATURE <b>James Chacaras</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/11/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Chacaras</b>		22e. ADDRESS <b>1521 Ritchie Hwy Arnold, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-10-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty Funeral Home 12 Ridgely Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Thacker</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

Film G 558 8-31-81 1- STATE REGISTRAR Item 19a 19b cn				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Henry Walter Atkins				2a. DATE OF DEATH MONTH DAY YEAR Aug. 9, 1981				2b. HOUR 4:30pm			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8346 Oakwood Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE MD.				13b. COUNTY AA		13c. CITY OR TOWN Millersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8346 Oakwood Road	
14. FATHER'S NAME FIRST MIDDLE LAST George Atkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Polly Plum							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 1				16b. SOCIAL SECURITY NO. 215-22-7730		17. INFORMANT ADDRESS 204 4th Ave. S.E. Mrs..Catherine Gaither, daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitotic Core Anaplastic</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Grub &amp; red - Air chel wear</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Cancer	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Age</u>											
19a. DATE OF OPERATION 6-4-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy-lesion anterior chest wall				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>76</u> , to <u>7/9</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>7/16/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Cliff Rateliff</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 10 Aug. 81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cliff Rateliff, Jr., MD				22e. ADDRESS Westview Mall, Catonsville, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 Aug. 81		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA MD			
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR AUG 11 1981		25b. REGISTRAR'S SIGNATURE <u>James S. Kirkley</u>					

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Aughinbaugh James L.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-3-81</b>		2b. HOUR <b>9:00<sup>AM</sup></b>
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 29, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>P.A.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Severna Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>402 Evergreen Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.C. Murphy Co.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Severna Park</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George B. Aughinbaugh</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Harmon</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>172-07-6987</b>		17. INFORMANT ADDRESS <b>L. Sue Aughinbaugh - Sec. 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive Lung Disease</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-15</b> , 19 <b>73</b> , to <b>8-3</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>10-6</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above, (I) (we) did) (did not) view the body after death.					
22b. SIGNATURE <b>Donald H. Hislop</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-03-1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald Hugh Hislop</b>		22e. ADDRESS <b>Severna Park, Maryland 21146 Robinson Road and Owens Way</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-6-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Indianapolis Ind.</b>	23e. DATE REC'D. BY REGISTRAR <b>AUG 5 1981</b>	
24. FUNERAL DIRECTOR NAME <b>Robert S. Barranco</b>		ADDRESS <b>501 Ritchie Hwy Severna Park MD.</b>		25. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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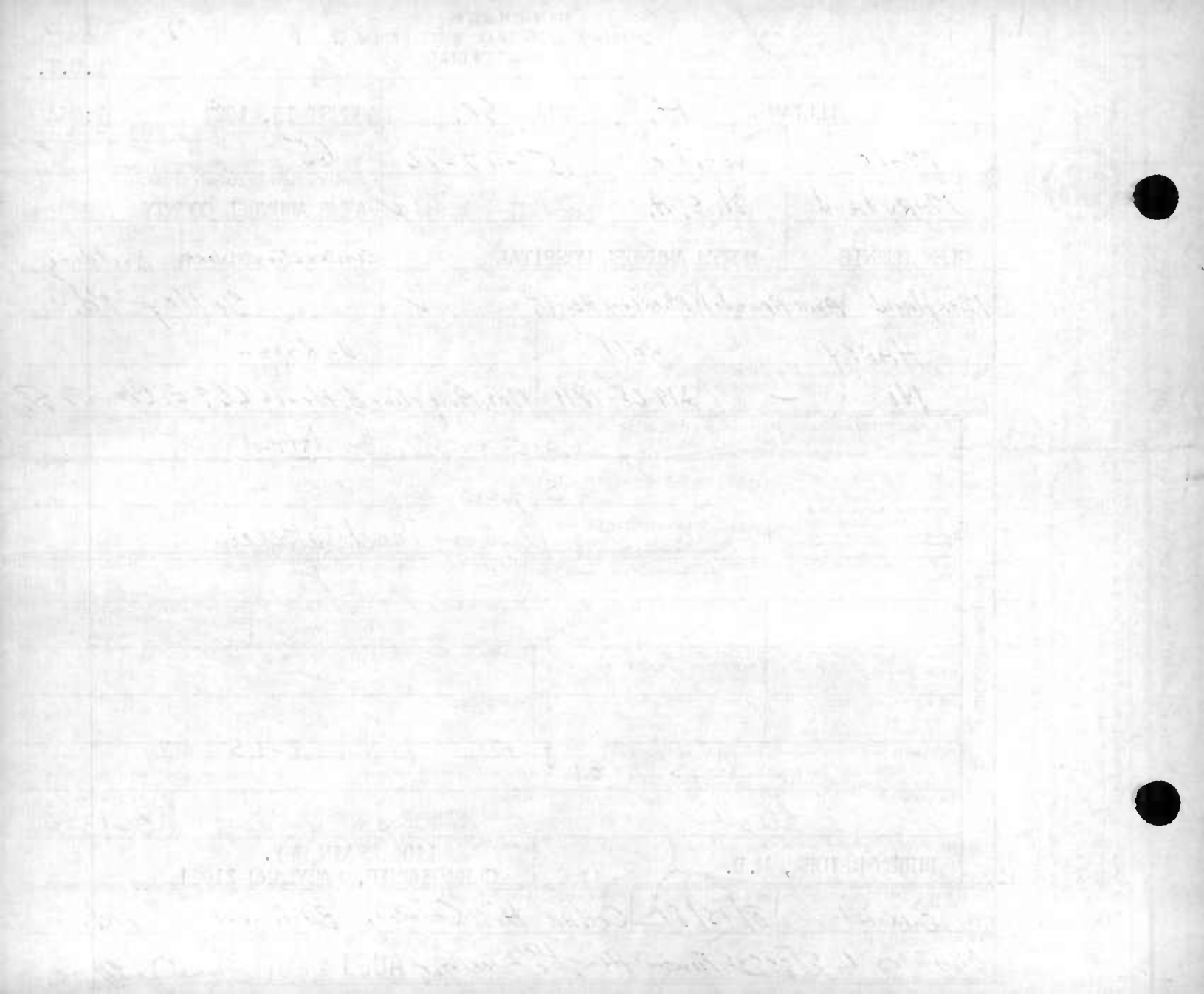
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 9 7 8 0							
FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.		E.D.T.					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					MONTH		DAY		YEAR		2b. HOUR	
WILLIAM H. BELL SR.					AUGUST 13, 1981											7:05A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		5-12-16		65 YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Construction Work		Building											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS							
13a. STATE					13b. COUNTY					13c. CITY OR TOWN							
Maryland					Anne Arundel					Pineley Heights							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME												
HARRY BELL					Dorothy												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS							
No					219-05-1811					Mrs. Angelina E. Heath 669 E. Chanters St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) - Cordicospinal Arrest																	
5990 DUE TO, OR AS A CONSEQUENCE OF (b) - Sepsis																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) - Urinary Tract Infection																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8-10 19 81 to 8-13 19 81, that (I) (we) last saw the deceased alive on 8-13 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE				DEGREE				22c. DATE SIGNED									
L. Reider								8-13-81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS													
RUBEN REIDER, M.D.				1406 CRAIN HWY. GLEN BURNIE, MARYLAND 21061													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				8/15/81		Cedar Hill Cemetery		Baltimore Md.									
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Charles L. Stevens Funeral Home, Inc.				AUG 14 1981				R. J. [Signature]									



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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8119781	
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Jane Bernstein						2a. DATE OF DEATH MONTH DAY YEAR 08-12-81		2b. HOUR 11 <sup>10</sup> A M			
3 SEX FEMALE		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 05-08-36		6 AGE (IN YEARS LAST BIRTHDAY) 45		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Honolulu T.H.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.					
10 CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (LIFE OR WORK OR MOST OF WORKING LIFE) A.A.C. Bd. Educ.		12b. KIND OF BUSINESS OR INDUSTRY CLERICAL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD.						13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS			
14 FATHER'S NAME FIRST MIDDLE LAST ALSIE P. MEDCALF Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MARUCH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. - 216 52 5232		17. INFORMANT ADDRESS JAMES C. BERNSTEIN #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ca PANCREAS</u> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/81</u> , 19____, to <u>8/12/81</u> , 19____, that (I) ( <del>we</del> ) lost saw the deceased alive on <u>8/12/81</u> , 19____, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE Stanley P. Watkins						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS						22e. ADDRESS 131 CATHEDRAL ST. ANNAPOLIS MD.					
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL				23b. DATE 8-15-81		23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEM.		23d. LOCATION ANNAPOLIS AA. MD.			
24. FUNERAL DIRECTOR NAME JOHN M. TAYLOR-SONS ANNAPOLIS MD.						25a. DATE REC'D. BY REGISTRAR AUG 14 1981					
25b. REGISTRAR'S SIGNATURE Anne Jan Mart...											



**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in accordance with the applicable laws of the state.

**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be placed in the outer envelope and sealed. The inner envelope should be placed in the outer envelope, both envelopes should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_  
MH - 16 50M 1/8  
(VRA 15, 4)

DHMH - 16 50M 1/81  
(VRA 15, 4)



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MELTON James BOUDREAUX					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 4, 1981			2b. HOUR 1250P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Growth, IA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver		12b. KIND OF BUSINESS OR INDUSTRY Self-Emp1.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. COUNTY AnneArundel		13d. CITY OR TOWN GlenBurnie		13e. STREET ADDRESS 732 Cotter Road	
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Boudreaux					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelye Cormier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) '47 - '49 436-32-0156		17. INFORMANT ADDRESS Mrs. Valerie A. Parker (Friend) Kent Rd., GlenBurnie			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1940</u> <u>Peptic and massive pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fracture of right foot</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic glioblastoma to the</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Carcinoma of the left adrenal gland</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dr. M. Presbitero</i>					DEGREE M.D.		22c. DATE SIGNED		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSE M. PRESBITERO MD.					22e. ADDRESS 325 HOSPITAL DR GLEN BURNIE, MD. 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7 AUG '81		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, Glen Burnie, Md.					25a. DATE REC'D. BY REGISTRAR AUG 6 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Thornton</i>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8119784			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nick George BOUNELIS</i>				2b. HOUR <i>8:25 PM</i>			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>May 12, 1893</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>88</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Turkey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.	
10 CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland Manor Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Restauranteur</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ret.</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>George Bounelis</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-32-5637A</i>	
17 INFORMANT <i>Frosso Bounelis</i>		ADDRESS <i>Same as #13</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-25-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MICHAEL PEARLMAN</i>		22e. ADDRESS <i>OLD COURT RD REISTERSTOWN, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 23, 1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Demetrius</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis A.A. MD.</i>	
24 FUNERAL DIRECTOR NAME <i>William M. Lough</i>		ADDRESS <i>Annapolis, Md</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 24 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 351-5411.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 7 8 5	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
JAMES Mc CUBIN BOURKE				AUGUST 21, 1981	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1886	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 94	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Linthicum	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Clay Bourke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Boone		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trust Dept.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I		17. INFORMANT Mrs. Jessie S. Bourke (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-3</u> , 19 <u>81</u> , to <u>8-21</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8-21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Sang C. DoH</u>				22c. DATE SIGNED 8-22-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.				22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24 AUG '81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE A.A. Md.		25a. DATE REC'D. BY REGISTRAR AUG 25 1981	
25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>					

BP \_\_\_\_\_

RECEIVED

W. J. WALKER





BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR					8 1 1978 6					
CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) TALLULAH CAREY BOYD					2a. DATE OF DEATH MONTH DAY YEAR 8-5-81			2b. HOUR 929 M		
3. SEX FEMALE		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 3 15 03		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1331 Douglass Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY D.C. Pub. Sch.		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO					13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Carey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tallulah McGeehee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 342-12-6682		17. INFORMANT ADDRESS Dr. John B. Boyd, Jr., 1331 Douglass Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>MONTHS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (a) (this hospital) attended the deceased from <u>8-1</u> 19 <u>81</u> , to <u>8-5</u> 19 <u>81</u> , that (b) (we) lost saw the deceased alive on <u>8-1</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ron Pickett M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-5-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD A. PICKETT				22e. ADDRESS 111 CATHEDRAL ST. ANNAPOLIS MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/10/81		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Virginia				
24. FUNERAL DIRECTOR NAME McGuire Funeral Serv. 7400 Georgia Ave. N.W.				Wash., D.C.		25. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



W. C. Sullivan

W. C. Sullivan

W. C. Sullivan

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81	1978	7
1 - FOR STATE REGISTRAR		REG. NO.								EDT		
1. DECEASED NAME (TYPE OR PRINT) MAMIE EVANS BREEDEN					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28, 1981			2b. HOUR P. 6:30 M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6 1886		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY, MD.						
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.												
13b. COUNTY A.A. Co		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (21061) 312 Fifth Ave S.E.						
14. FATHER'S NAME FIRST MIDDLE LAST Howard Evans				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Bonnie Ruark same as 13 e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 5850 DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE METABOLIC ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE EXAGGERATION OF CHRONIC RENAL FAILURE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, CHF.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 8/26, 1981, to 8/28, 1981, that (I) (we) lost saw the deceased alive on 8/28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Surya P. Mundra				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/28/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYA P. MUNDRA, M.D.				22e. ADDRESS 205 Baltimore-Annapolis Blvd. Glen Burnie, Maryland, 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.						
24. FUNERAL DIRECTOR NAME Balto Md. ADDRESS 21225 George J. Gonc 4001 Ritchie Hgwy				25a. DATE REC'D. BY REGISTRAR SEP 2 1981		25b. REGISTRAR'S SIGNATURE James Van Notten						

BP



DDMM - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				EDT							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIE E. BRIDGES</b>								2a. DATE OF DEATH MONTH DAY YEAR <b>8-13-81</b>				2b. HOUR <b>1:55 PM</b>							
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1931</b>				6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>50</b>				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.											
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Clerk</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. H &amp; K</b>							
13a. STATE <b>MD</b>								13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>304 Maple Lane, N. W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edwin Knauss</b>								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Smith</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>204-24-9964</b>				17. INFORMANT ADDRESS <b>Albert C. Bridges, Same as 13</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>5374</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE RESPIRATORY DISTRESS SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUODENAL STUMP FISTULA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b> <b>2 DAYS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHRONIC PEPTIC ULCOR</b>																			
19a. DATE OF OPERATION <b>8-11-81</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DUODENAL STUMP FISTULA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>8-5</b> 19 <b>81</b> , to <b>8-13</b> 19 <b>81</b> , that (I) (most) last saw the deceased alive on <b>8-13</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) use the body after death.																			
22b. SIGNATURE <b>ADOLFO G. TORRES</b> MD												22c. DATE SIGNED <b>8-13-81</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ADOLFO G. TORRES, M.D.</b>												22e. ADDRESS <b>7845 OAKWOOD RD. SUITE 201 GLEN BURNIE, MD. 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>17 Aug. 81</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>							
24. FUNERAL DIRECTOR NAME <b>James S. Kirkley, Glen Burnie, MD</b>												25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1981</b>				25b. REGISTRAR'S SIGNATURE <b>James S. Kirkley</b>			

10-21-81

SECRET  
DIRECTOR, FBI  
FROM: SAC, NEW YORK

URGENT 10-21-81

RE: [illegible]

10-21-81

10-21-81

10-21-81

10-21-81

10-21-81



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Robert P Brosseau</b>					2a. DATE OF DEATH MONTH <b>8</b> DAY <b>24</b> YEAR <b>81</b>			2b. HOUR <b>0811 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>26</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>General Manager C.C. Murphy Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>17 Woodland Dr.</b>			
14. FATHER'S NAME FIRST <b>Harvey</b> MIDDLE <b>L.</b> LAST <b>Brosseau</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b>M.</b> LAST <b>Boivert</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WATII</b>		17. INFORMANT ADDRESS <b>Mildred L. Brosseau - Sec. 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respirator failure</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Superior Vena Caval Syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cx of lung &amp; metastasis to chest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>72 hr</b> <b>3 months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) <b>Wall and mediastinum</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the <del>physician</del> ) attended the deceased from <b>June 1</b> 19 <b>81</b> to <b>August 24</b> 19 <b>81</b> that (I) ( <del>was</del> ) lost saw the deceased alive on <b>24 August</b> 19 <b>81</b> , and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <b>Gary M. Richardson, M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-24-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GARY M. Richardson, MD</b>						22e. ADDRESS <b>104 Forbes Street, Annapolis, MD 21401</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>8-26-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>			23d. LOCATION CITY OR TOWN <b>Westview</b> COUNTY <b>Balto</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Robert S. Barranco</b>						ADDRESS <b>501 Ritchie Hwy</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION





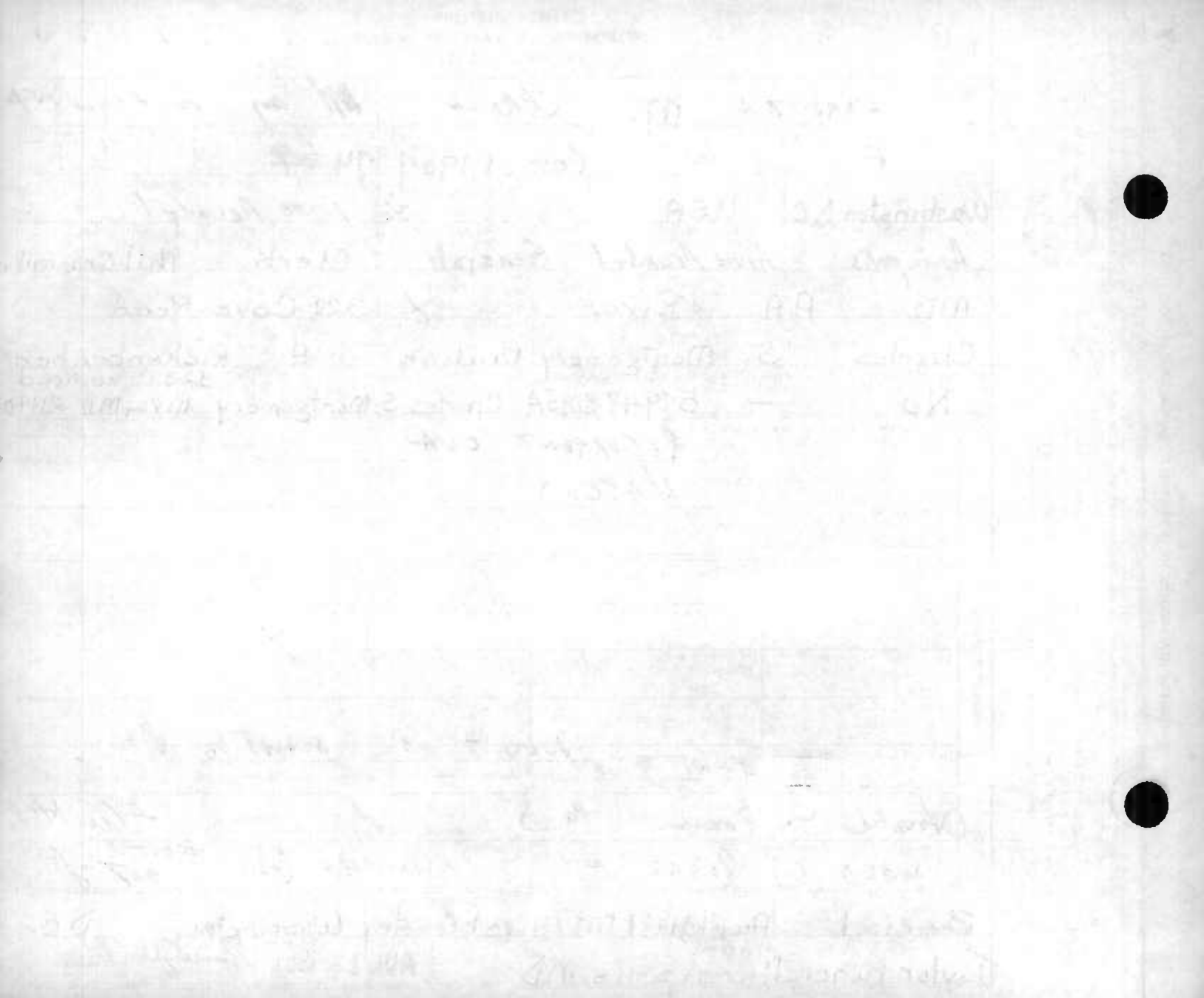
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8119790	
FOR 1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LORETTA M. Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 10 81</b>		2b. HOUR <b>4:55 PM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 1, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			10. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>General</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Natl Geographic</b>			13a. STREET ADDRESS <b>321 Cove Road</b>		
13b. CITY OR TOWN <b>Annapolis</b>			13c. CITY OR TOWN <b>Riva</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>321 Cove Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles S. Montgomery</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline A. Rickenbacher</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>57948-8085A</b>		
17. INFORMANT <b>Charles S. Montgomery</b>			ADDRESS <b>323 Cove Road Riva, MD 21140</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECURRENT CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>HASCD</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>4029</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>July 7 1981</b> to <b>August 10 1981</b> , that (we) lost saw the deceased alive on <b>August 9 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Donald C. Roane</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/10/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald C. Roane M.D.</b>		22e. ADDRESS <b>134 OVENHILL ROAD WEST RIVER 20778</b>			
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>		23b. DATE <b>Aug 13 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemet</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 14 1981</b>			
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>		ADDRESS <b>Annapolis, MD</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 7 9 1	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	EDT
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>CHARLES H. BUCKALEW</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 2, 1981</b>	2b. HOUR <b>9:20 P M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 24, 1910</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>New Jersey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK, ADDRESS OF WORK, INDUSTRY) <b>draftsman (ret)</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Reg.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>AA</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>613 Marshall Rd.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clifford Buckalew</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Hankins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAIVER DATES) <b>WW II 028/07/6155</b>	17. INFORMANT ADDRESS Same as 13 <b>Mrs. Lillian A. Buckalew *wife)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic clonus</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>num - ASA - cardiac arrest</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>4/28/81</b> , 19____, to <b>8/2/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>8/1/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JORGE B. RAMIREZ, M.D.</b>		22e. ADDRESS <b>7845 Oakwood Road #205 Glen Burnie, Maryland 21061</b>		22f. PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>	23b. DATE <b>3 August 81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Security Process Inc.</b>		23d. LOCATION CITY OR TOWN STATE <b>Catonsville Balt, MD</b>	
24. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home, Glen Burnie, MD</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>AUG 6 1981</b>	



30% COTTON FIBER

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 7 9 2

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John J Burl Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-8-81</b>		2b. HOUR <b>8:35 AM</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2-04-16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AA Gen Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Annapolis</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS <b>19 N. Glen Ave</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES J. Burl</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HMEHIA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>15-03-3169</b>		17. INFORMANT NAME ADDRESS <b>CHARLES W. Burl 2194 GLENFIELD RD Annapolis</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Oat Cell Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>1629</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <b>7/27</b> 19 <b>81</b> to <b>8/8</b> 19 <b>81</b> , that (1) we lost saw the deceased alive on <b>8/5</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (we) did not view the body after death.						
22b. SIGNATURE <b>Emes W. Cole</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/8/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ENSER W. COLE</b>		22e. ADDRESS <b>121 CATHEDRAL ST ANNAPOLIS MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/10/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HICKORY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis AA MD.</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>JOHN M. TAYLOR &amp; SONS Annapolis MD</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>AUG 12 1981</b> <b>James J. North</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

DHMH-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 9 7 9 3	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nonbert Herbert Businsky</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>August 23, 1981</i>		2b. HOUR <i>8 p</i> M <i>approx</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 19, 1912</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>U.N. Arundel Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machinist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Anne Arundel</i> 13c. CITY OR TOWN <i>Pasadena</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1251 Magothy Rd. 21122</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Stanley Businsky</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Misch</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-07-9060</i>		17. INFORMANT ADDRESS <i>Virginia A. Businsky Same as #13</i>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>essential hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i> <i>10 years.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>diabetes mellitus 7 years.</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/30</i> 19 <i>67</i> , to <i>8/23</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>7/15</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <i>R. M. McLaughlin, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/24/81</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Randall Mc Laughlin, M.D.</i>				22e. ADDRESS <i>3708 Mountain Rd., Pasadena, Md. 21122</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/27/1981</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, A. Arundel, Md.</i>
24. FUNERAL DIRECTOR NAME <i>Mc Cully T.H. Mtn. &amp; Tick Neck Rds., Pasadena, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 26 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Francis Santharone</i>

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سید احمد علی

1. The first part of the paper is devoted to a review of the literature on the topic of the role of the state in the development of the economy. It is found that the state has played a significant role in the development of the economy in many countries, particularly in the case of developing countries. The state has been able to mobilize resources, provide infrastructure, and create a favorable environment for investment and growth.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	9	7	9	4							
1. FOR STATE REGISTRAR										REG. NO.						EDT						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR		
ROBERT MORRIS CAMPBELL										AUGUST				20		1981		1:54		A M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS							
Male			White			4 24 YRS			90			MONTHS			DAYS			HOURS			MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania					U.S..A.										ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY							
GLEN BURNIE					NORTH ARUNDEL HOSPITAL					Train Mfg					Estimator Co							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
										Md.		A.A. Co.		Millersville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		336 Md. Rt. 3 South				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																	
William Campbell					Margaret Bell																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS							
No					190-18-6099					Margaret Fellows					336 Md. Rt. 3 South							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4960 DUE TO, OR AS A CONSEQUENCE OF: (b) Severe obstructive COPD - DUE TO, OR AS A CONSEQUENCE OF: (c) APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d): Aortic - myocardiocler																						
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE												
22a. I certify that (1) (the hospital) attended the deceased from 8/19/81 to 8/20/81, that (2) (we) last saw the deceased alive on 8/19/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (initialed) (and not) view the body after death.																						
22b. SIGNATURE Jorge B. Ramirez, M.D.					22c. ADDRESS 7845 Oakwood Road #205 Glen Burnie, Maryland 21061					22d. DATE SIGNED 8/20/81												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (CITY OR TOWN) COUNTY STATE							
Cremation					8/21/81					Westview Mem. PK.					Catonsville Balto. Md.							
24. FUNERAL DIRECTOR George J. Gonce					4001 Ritchie HWY. Balto., Md. 21225					25a. DATE REC'D. BY REGISTRAR AUG 24 1981					25b. REGISTRAR'S SIGNATURE Anne J. [Signature]							

14.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 7 9 5

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <del>CAREY</del> EMILY BRIMER CAREY			2a. DATE OF DEATH MONTH DAY YEAR 8/25/81		2b. HOUR 4:40 M								
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct 13, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.							
10. CITY OR TOWN OF DEATH Arnold		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) 1445 Grandview Rd.				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Avon					
13a. STATE MD.						13b. COUNTY A.A.		13c. CITY OR TOWN Arnold		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1445 Grandview Rd.	
14. FATHER'S NAME FIRST LAST Joseph E. Brimer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Evans									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT ADDRESS Joshua A. Carey #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA BREAST 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1979, 19, to 8/25/81, 19, that (I) (we) lost saw the deceased alive on 8/20/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Stanley P. Watkins						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS						22e. ADDRESS 121 CATHEDRAL ST. ANNAPOLIS MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/27/81		23c. NAME OF CEMETERY OR CREMATORY Asbury Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arnold B. Annapolis MD					
24. FUNERAL DIRECTOR NAME John M. Taylor Sons						ADDRESS Annapolis MD.		25a. DATE REC'D. BY REGISTRAR AUG 26 1981					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 1 of 2)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

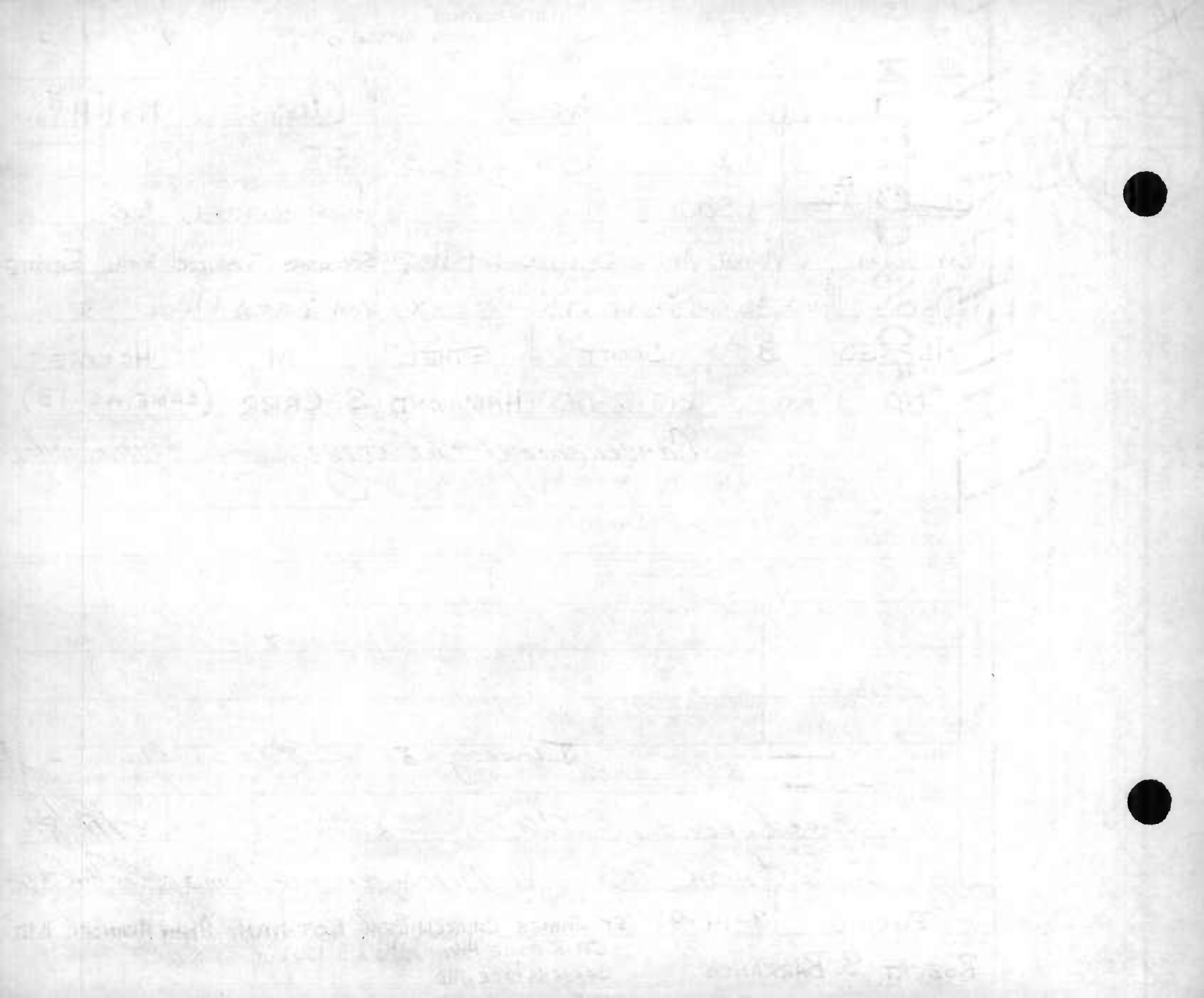
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1979	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
Beverly S. Carr			August 11, 1981		11:37 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE	W	5-27-23	58 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (CITY AND STATE)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
W. VA.	USA		ANNE ARUNDEL CO. MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis	ANNE ARUNDEL GENERAL HOSP		SECRETARY - TREASURER		REAL ESTATE	
13. STATE	14. CITY OR TOWN	15d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
MD	ANNE ARUNDEL	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	204 SEVEN RIVER RD			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME					
ALFRED B SCOTT	ETHEL M HOLMES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> NO <input checked="" type="checkbox"/> )		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO		219-18-7758	HAMMOND S. CARR (SAME AS 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>January 1981</u> to <u>8/11</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8/11</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.		22b. SIGNATURE <u>R. I. Hochman, MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/11/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. I. Hochman, MD</u>		22e. ADDRESS <u>16 Murray Avenue, Annapolis, Md 21401</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>8-14-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CHURCH CEM</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>LOTHAM, ANNE ARUNDEL MD.</u>
24. FUNERAL DIRECTOR NAME <u>ROBERT S. BARRANCO</u>		ADDRESS <u>501 RITCHIE HWY SEVERNA PARK, MD</u>		DATE RECEIVED BY REGISTRAR <u>AUG 14 1981</u>		





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Daniel Carver</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 11 19 81</b>			2b. HOUR <b>AM</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 6 54</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>27 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>27</b>	IF UNDER 24 HRS. HOURS MIN. <b>00</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8 12 19 81</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas C. Carver, Jr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jule More</b>			16. SOCIAL SECURITY NO. <b>214-62-0336</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			17. INFORMANT ADDRESS <b>Linthicum Md.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nicotine Poisoning</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 8/11/19 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject ingested Nicotine</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>309 Greenwood Rd. Linthicum A.A. Co., Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>			TITLE (SPECIFY) <b>M.D. Assistant</b>			DATE SIGNED <b>8-13-81</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>			ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>8/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>			ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1981</b>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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15M 2/80



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Student

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Carney, W. J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer. Page 4 should be filed in the office of the health officer.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) ADELAIDE J. CAULK			7a. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1981			7b. HOUR 5:20 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 02 08		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7c. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE OPERA-		12b. KIND OF BUSINESS OR INDUSTRY MONTGOMERY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. CITY OR TOWN GLEN BURNIE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS TOR WARD 912 LANGLEY ROAD, 21061	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT ERNSTBERGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE HOLT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-0100		17. INFORMANT ADDRESS MARY ELLEN EBERHART 912 LANGLEY ROAD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED INTRAVASCULAR COAGULATION DUE TO, OR AS A CONSEQUENCE OF (c) GANGRENOUS COLITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 24 HRS. 5 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ACUTE RENAL FAILURE									
19a. DATE OF OPERATION 8-11-81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENOUS COLITIS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 8-8-81 to 8-13-81, that (I) (we) lost saw the deceased alive on 8-13-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE ADOLFO G. TORRES, M.D.				DEGREE		22c. DATE SIGNED 8-13-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADOLFO G. TORRES, M.D.	
22e. ADDRESS 7845 OAKWOOD RD. SUITE 102 GLEN BURNIE, MD. 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08-17-81		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR AUG 17 1981		25b. REGISTRAR'S SIGNATURE	

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DHMH: 16 30M 2/80  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 / 9 9			
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Henry T Coffin				8 8-3-81			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
male		white		MONTH DAY YEAR		81 YRS.	
3-31-00							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD.		U.S.A.				Anne Arundel MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hosp. Dept. Public Works Civil Service				(Ret)	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		A.A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Lincoln Drive			
Henry S. Coffin		Sarah Brewer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-03-4297		Agnes Walters.		29 W. Washington St Annapolis, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CVA							
2500 DUE TO, OR AS A CONSEQUENCE OF							
(b) Diabetes							
DUE TO, OR AS A CONSEQUENCE OF							
(c) ASCVD							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from 1980, 19, to 8/3/81, 19, that (we) last saw the deceased alive on 8/3/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Stanley P Watkins		ATTENDING PHYSICIAN		8/3/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
STANLEY P WATKINS		121 Cathedral St, Annapolis, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Aug. 6, 1981		Cedar Bluff		Annapolis A.A. MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Taylor Funeral Chapel, Annapolis, Md		AUG 6 1981		[Signature]			



Vertical text on the right margin, possibly a date or page number, including the number '2' at the bottom.

Main body of the document containing several lines of extremely faint, illegible text, possibly bleed-through from the reverse side.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William David Conner, Sr.			2a. DATE OF DEATH MONTH DAY YEAR Aug. 17, 1981			2b. HOUR 10 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 9, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Annapolis Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN A.A.Co.		13c. STREET ADDRESS Same as at #13 7632 Beach Dr. 2112 Pasadena, Md.				
14. FATHER'S NAME FIRST MIDDLE LAST David Reed Conner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Miliam						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 407-09-9333		17. INFORMANT ADDRESS Mrs. Ona W. Conner, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC + RHEUMATIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4140 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 MINUTES - 20 YEARS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>12-31-1962</u> , to <u>8-17-1981</u> , that (I) (we) last saw the deceased alive on <u>6-5-1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Carlton L. Sexton, M.D.				DEGREE M.D.				22c. DATE SIGNED 8-18-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLTON L. SEXTON, M.D.				22e. ADDRESS 819 PARK AVE., BALTIMORE, MD, 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 22, 1981		23c. NAME OF CEMETERY OR CREMATORY Clendenin Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Clendenin Kanawha W. Va.			
24. FUNERAL DIRECTOR NAME McGully Funeral Home, Mt. & Ticken Rds. Pasadena				25. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE Thane J. Smith			

M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VRA 15 ME (3))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA MAE CONSTANT</b>			2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>8 15 1981</b>			7b. HOUR <b>7A</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>June</b> DAY <b>24</b> YEAR <b>1919</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>62</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>15</b> YEAR <b>1981</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. Anne Arundel Co. MD.</b>		
10. CITY OR TOWN OF DEATH <b>Severn</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>341 Constant Ave. - Severn</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Exxon Chem.</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>341 Constant Avenue</b>
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>A.</b> LAST <b>Shriver</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b>Grace</b> LAST <b>Martin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT (Daughter) <b>Mrs. Gloria A. Griffin, Balto., MD.</b>		ADDRESS <b>901 Rambling Dr</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>E. Linhardt</b>			TITLE (SPECIFY) M.D. <b>Deputy</b>			MEDICAL EXAMINER		DATE SIGNED <b>5.15.81</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>			ADDRESS <b>Annapolis, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 20, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Glen Burnie, A.A., MD.</b> COUNTY		
24. FUNERAL DIRECTOR NAME <b>G. N. Hopkins</b>			Glen Burnie MD.		25. DATE REC'D. BY REGISTRAR <b>AUG 20 1981</b>		BY REGISTRAR <b>James J. [Signature]</b>	
Singleton Funeral Home								

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U.S. DEPT. OF AGRICULTURE  
WASHINGTON



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 0 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada Marie Conway			2a. DATE OF DEATH MONTH DAY YEAR 8 3 81			2b. HOUR M M	
3. SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 26 1927		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD	
10 CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor Con. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Arundel Co.		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Chesten Dorsey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Bias					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-22-1544		17 INFORMANT ADDRESS Severn, Md. 21144 Mr. William Dorsey 1913 Champlain Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4259 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Viral Cardiomyopathy</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Liver Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Aug 3</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>James S Rhodes</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8-3-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P R RHODES MD</u>		22e. ADDRESS <u>1667 Crofton Center Crofton Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/81		23c. NAME OF CEMETERY OR CREMATORY Macedonia U.M. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.	
24 FUNERAL DIRECTOR NAME <u>Herbert E. NUTTER FUNERAL HOME</u>		ADDRESS <u>BALTO; md. 21216</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 6 1981</u>		25b. REGISTRAR'S SIGNATURE <u>James S Rhodes</u>	

BP



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edy The Lillian Daly			2a. DATE OF DEATH MONTH DAY YEAR 8 28 81		2b. HOUR 10 <sup>15</sup> am
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 9 08	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bridgeport Conn.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Property mgr.	12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE Md.	13b. COUNTY A.A.Co.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3738 Ramsgate Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Oswald Meyhoefer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Unsderfer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 087-32-7855		17. INFORMANT Phyllis Daly	
				ADDRESS 3738 Ramsgate Dr. Ann. Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable myocardial rupture DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 7 days Yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1) Hypothyroidism 2) Paget's Dis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/27/81 to 8/28/81, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so we did not.)					
22b. SIGNATURE Joseph N. Friend		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN NAME (TYPE OR PRINT) Joseph N. Friend		22e. ADDRESS 205 Ridgely Ave Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/1/81		23c. NAME OF CEMETERY OR CREMATORY Cypress Hills Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Glendale Queens Co. N.Y.		24. FUNERAL DIRECTOR NAME ADDRESS Hardesty Funeral Hme 12 Ridgely Ave. Ann. Md.			

SEP 3 1981





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 8 0 4	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST MILDRED BRYAN DANIELS				MONTH DAY YEAR AUGUST 19, 1981	
3. SEX				2b. HOUR	
Female				2:55P M	
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)	
Caucasian				57 YRS	
5. DATE OF BIRTH				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MONTH DAY YEAR 3-16-1924				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania				ANNE ARUNDEL COUNTY MD.	
7b. CITIZEN OF WHAT COUNTRY?				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
U.S.A.				Shop Owner- Self employed	
10. CITY OR TOWN OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
NORTH ARUNDEL HOSPITAL					
13a. STATE				13b. COUNTY	
Md.				Anne Arun	
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?	
Glen Burnie				YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Charles Bryan				FIRST MIDDLE LAST Grace Seanor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.	
No				199-16-9240	
17. INFORMANT				ADDRESS	
Percy Daniels				Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) - Respiratory Arrest.				10'	
DUE TO, OR AS A CONSEQUENCE OF					
(b) Brain Stem Metastases				4 months	
DUE TO, OR AS A CONSEQUENCE OF					
(c) Lung Adeno Carcinoma				2 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-7-81 19 81 to 8-19 19 81, that (I) (we) last saw the deceased alive on 8-19 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
RUBEN REIDER, M.D.				8-19-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
				1406 CRAIN HWY., GLEN BURNIE, MARYLAND 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		8-22-81		Ft. Lincoln	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Beall Funeral Home		Brentwood Pr. Geo. Md.		AUG 24 1981	
16,000 Annapolis Rd. Bowie, Md.				REGISTRAR'S SIGNATURE	

BP



301

AUGUST 12, 1941      MICHAEL      BRYAN      DANIELA

Female      Caucasian      3-16-1924      27

Pennsylvania, U.S.A.      8      ANNE ARUNDEL COUNTY

GLENN BURNETT      NORTH ARUNDEL HOSPITAL      Shop Owner - Self Employed

Mr.      Anne Arun Burnett      1221 Defense Highway

Charles      Bryan      Grace      2600

No      192-16-9240 Percy Daniela Same as W 12



1940      DANIELA      BRYAN      MICHAEL

16,000      8-22-41      25      Lincoln

16,000      8-22-41      25      Lincoln

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jessie B DAVIS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8-3-81</b>		2b. HOUR <b>2:30 AM</b>	
3 SEX <b>F</b>	4 RACE <b>N</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-20-92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL Co</b> MD.	
10. CITY OR TOWN OF DEATH <b>Lincolnton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lincoln General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>ANNAPOLIS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>107 Clay Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY E. BRYAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-32-1428</b>		17. INFORMANT ADDRESS <b>JOHN BRYAN 118 Southville Ave. Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4149 Large heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>17 chronic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/3/67</b> , 19____, to <b>8/3/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>8/2/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John M. Ryan</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>8-3-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHANN CHURCH</b>		22e. ADDRESS <b>8 EVERGREEN LANE BOWMAN PARK</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-7-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>AUG 5 1981</b>			
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>		25. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

BP



RECEIVED  
JAN 10 1954  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

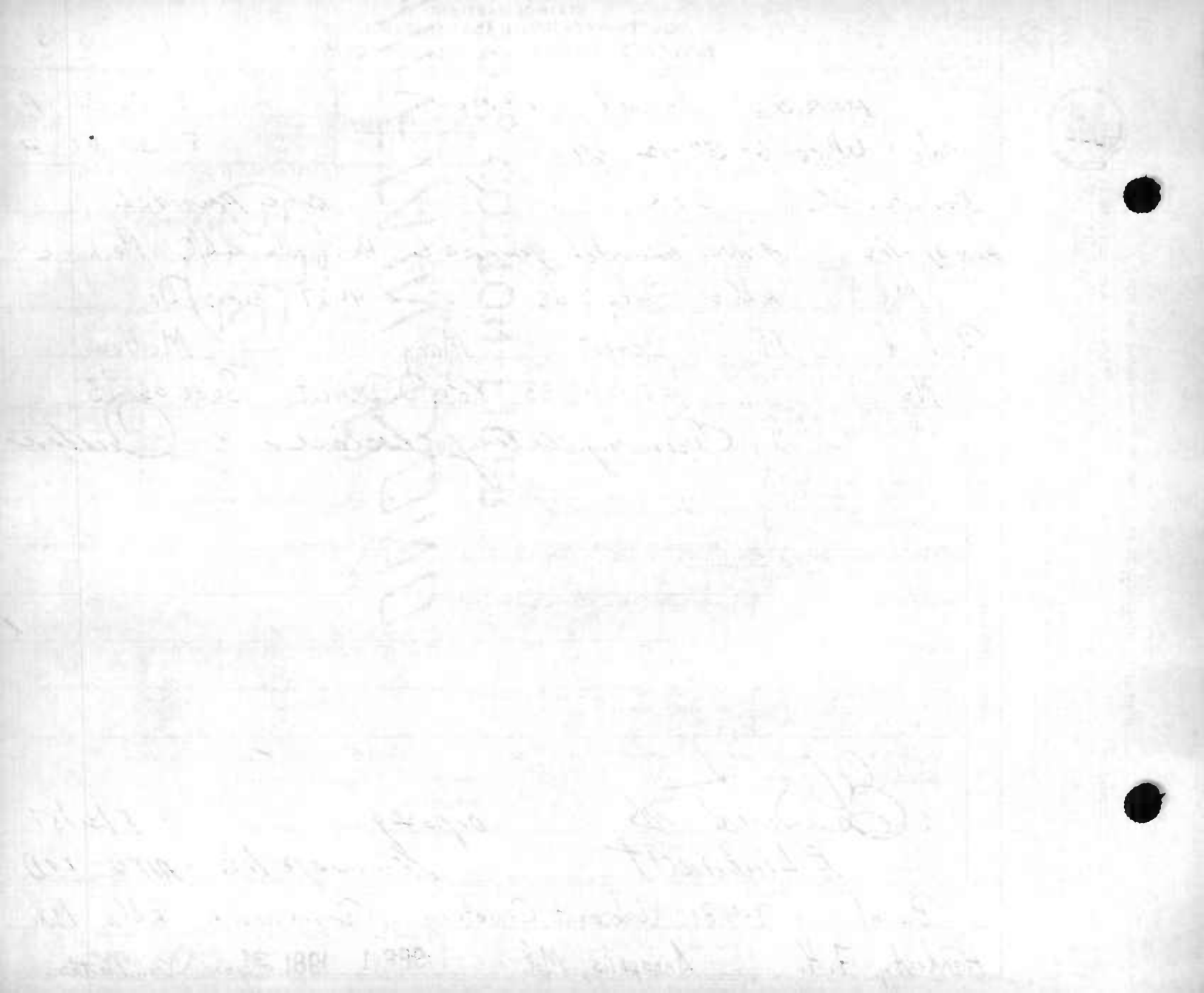
12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VRA 15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19806	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRIS Leonard DEMENT										2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 30 1981	
3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. YRS. 8. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 9. IF UNDER 24 HRS. MONTH DAY YEAR 24 HOUR Male White 6-30-12 69 YRS.										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 24 HOUR 8 30 81 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY Annapolis ANNE ARUNDEL GENERAL Refrigeration & A/C Mechanic											
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Md. AACo Shady Side YES NO 4927 Thomas Dr.											
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Richard M. Dement Mary McVey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS No 577-07-3153 Kate D. Dement Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Disease</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										18. EXACT TIME INTERVAL BETWEEN ONSET AND DEATH Dinner	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED E. LINHARDT M.D. Depo 49 5/31/81											
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS E. LINHARDT Annapolis - ARKO-LID											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE Burial 9-1-81 Lakemont Cemetery Davidsonville AACo Md.											
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Hardesty, F.H. Annapolis, Md. SEP 1 1981 Frances Van Natten											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M / 81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 8 0 7	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH M DOVE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>8 8 81</b>			2b. HOUR <b>6 40</b> AM			
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 24 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL MD.</b>					
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) <b>H. AGEN.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. USUAL RESIDENCE (IF IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) <b>MD. 14. A. Edgewater</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <b>1507 Fuberton Rd.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Irving KING</b>		15. MOTHER'S MIDDLE NAME <b>Minnie</b>		16. LAST KING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212 26 7878</b>		17. INFORMANT <b>George H. Dove #13</b>		ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>portal hypertension</b> <b>5714</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic active hepatitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>= 1 mo</b> <b>= 1 yr</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>obesity, recurrent thrombophlebitis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>8-30</b> , 19 <b>81</b> , to <b>8-8</b> , 19 <b>81</b> , that (b) (we) last saw the deceased alive on <b>8-7</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G Mitchell MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-8-81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G Mitchell, MD</b>		22e. ADDRESS <b>1616 Ford Dr Annapolis MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>8/11/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WHEATMONT</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DAVIDSONVILLE AA MD.</b>					
24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>John M. Taylor</b>		ADDRESS <b>Annapolis MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1981</b>		REGISTRAR'S SIGNATURE <b>Theresa J. ...</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Ellsworth Draper			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1981		2b. HOUR 11:30 PM
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1929	6 AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10 CITY OR TOWN OF DEATH Glen Burnie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 600 Aquahart Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maint. Super.	12b. KIND OF BUSINESS OR INDUSTRY Glidden Corp	
13a. STATE Md.			13b. COUNTY AA	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Draper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Dixon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1948-1952	17. INFORMANT ADDRESS Doris L. Draper, wife, same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer with brain metastasis 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 24, 1970, to present, that (I) (we) lost saw the deceased alive on July 24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jose M. Presbitero, M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 18 Aug. 81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin A. deGuzman, M.D.			22e. ADDRESS Suite 108, 325 Hospital Drive, Glen Burnie, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE 20 Aug. 81	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA, Md.	25a. DATE RECEIVED BY REGISTRAR AUG 20 1981	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md.			25b. REGISTRAR'S SIGNATURE Name Jose Presbitero		

MEDICAL CERTIFICATION



NOTICE

James E. Kirkley, Glen Ridge, N.J.

August 1942

Information: 20 copies of this report sent to the following:  
1. Mr. J. Edgar Hoover, U.S. Department of Justice  
2. Mr. Clegg, U.S. Department of Justice  
3. Mr. Glavin, U.S. Department of Justice  
4. Mr. Ladd, U.S. Department of Justice  
5. Mr. Nichols, U.S. Department of Justice  
6. Mr. Rosen, U.S. Department of Justice  
7. Mr. Tracy, U.S. Department of Justice  
8. Mr. Carson, U.S. Department of Justice  
9. Mr. Egan, U.S. Department of Justice  
10. Mr. Gurnea, U.S. Department of Justice  
11. Mr. Hendon, U.S. Department of Justice  
12. Mr. Pennington, U.S. Department of Justice  
13. Mr. Quinn, U.S. Department of Justice  
14. Mr. Nease, U.S. Department of Justice  
15. Mr. Gurnea, U.S. Department of Justice  
16. Mr. Egan, U.S. Department of Justice  
17. Mr. Hendon, U.S. Department of Justice  
18. Mr. Pennington, U.S. Department of Justice  
19. Mr. Quinn, U.S. Department of Justice  
20. Mr. Nease, U.S. Department of Justice

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must verify the cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Helen M. Drury</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>8 23 81</i>			2b. HOUR <i>6:05 P<sub>M</sub></i>	
3 SEX <i>F</i>		4 RACE <i>Caucasion</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Feb. 19, 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland Manor Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>H.A. Annapolis</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>819 Boucher Ave.</i>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <i>W. M. Catlin</i>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Betty Crutchley</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-32-2476</i>		17. INFORMANT ADDRESS <i>Hazel M. Jocus #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bacterial Sepsis</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>multiple CVA's</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>years</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did (I) did not view the body after death.)									
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>8-23-81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael B. Pearlman, M.D.</i>				22e. ADDRESS <i>Old Court Rd. Randallstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/27/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis H.A. MD.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>John M. Taylor &amp; Sons Annapolis, MD.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 26 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Helena M. Drury 8-23-81 1:00

Concession 22

MD. W. B. A.

For Service and Transportation

MD. W. B. A.

W. B. A.

No. 12

Section 12

Section 12

Section 12

Section 12

Section 12

Section 12

Section 12

Section 12

Section 12

Section 12

Section 12



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 1 1 9 8 1 0

## CERTIFICATE OF DEATH

REG. NO.

EDT

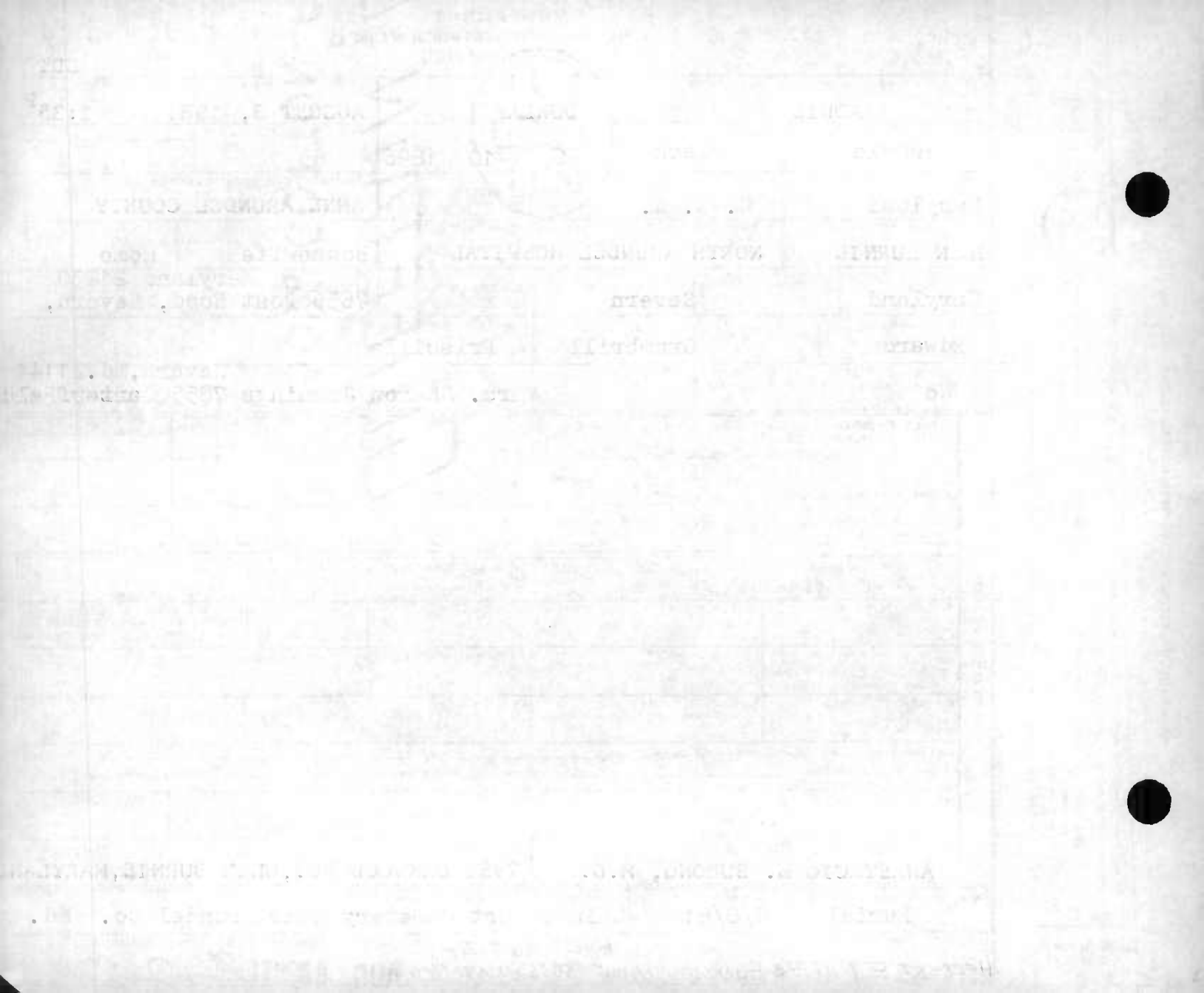
1- FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
ADDIE DUNLAP		Female		Black	
5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS	
6 MONTH 10 YEAR 1896		85 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U. S. A.			
9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
ANNE ARUNDEL COUNTY MD.		GLEN BURNIE		NORTH ARUNDEL HOSPITAL	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS	
Housewife		Home		Maryland 21230	
13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Severn			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Edward Grambrill		Priscilla		No	
16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line. Part 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
		Severn, Md. 21144		4049 <i>Coronary Artery Disease</i>	
		Mrs. Sharon Jennings 7855 Quarterfield		4049 <i>Coronary Artery Disease</i>	
				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
				AK irregular HT. Terminal Coronary Artery Disease	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b IF YES (WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?) YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE DEGREE		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE REC'D. BY REGISTRAR	
ANASTASIO E. SUBONG, M.D.		7951 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061		AUG 6 1981	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		8/8/81		Saints Rest Cemetery	
23d LOCATION (CITY OR TOWN COUNTY STATE)		23e DATE REC'D. BY REGISTRAR		23f REGISTRAR'S SIGNATURE	
Anne Arundel Co. Md.		AUG 6 1981		Name of Registrar	
24 FUNERAL DIRECTOR NAME		24b ADDRESS		24c DATE REC'D. BY REGISTRAR	
HERBERT E. NUTTER FUNERAL HOME		3035 W. NORTH A		AUG 6 1981	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the (hospital) director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 8 1 1	
FOR STATE REGISTRAR				REG. NO.	
CERTIFICATE OF DEATH				EDT	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTHA KATHRYN EBAUGH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 1, 1981</b>		2b. HOUR <b>3:35 P M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 30 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>A.A. Co.</b>	13c. CITY OR TOWN <b>Glen Burnie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James LLOYD</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catheryne MUNDIS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 76 3891</b>		17. INFORMANT ADDRESS <b>Lewis P. Ebaugh same as 13 e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Resp. arrest</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>C. C. H.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. Kaplan</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC A. KAPLAN, M.D.</b>		22e. ADDRESS <b>7845 OAKWOOD ROAD, #200 GLEN BURNIE, MARYLAND 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>		Baltimore Md. 21225 ADDRESS <b>4001 Ritchie Hgwy</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Hester</b>					

BP

DHMM-16 50M 1/81  
(VRA 15, 4)

171

1951:03:23

WASH DC

KATHRYN

1951:03:23

Female

White

March 20 1917

X

D.O.B.

Pensylvania

ALMA ABRAMS

NORTH ARMISTED HOSPITAL

ALMA ABRAMS

X - 1900 1905

A.S. 20. after birth

WASH DC

Washington

1917

James

215 70 - 1917 - 1917 - 1917 - 1917

701 CARROLL ROAD, WASH DC  
GARLAND BUILDING, WASHINGTON FIELD

MARC A. KATHRYN, M.D.

1917 - 1917 - 1917 - 1917 - 1917

1917 - 1917 - 1917 - 1917 - 1917

1917 - 1917 - 1917 - 1917 - 1917

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN VITAL RECORDS. TO PAPER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

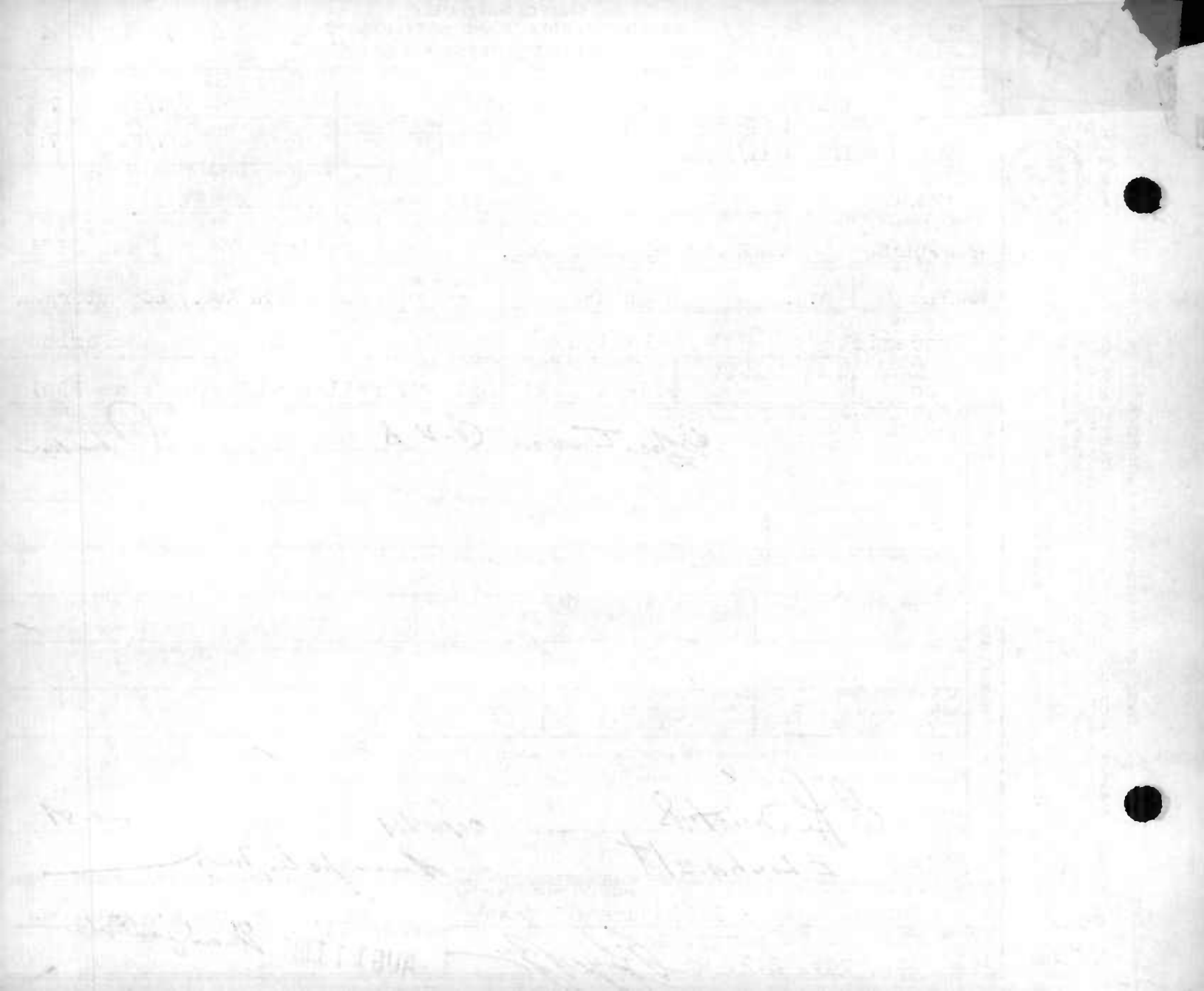
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		21. HOUR	
WALTER		M.		FALLON				8/7/81		19		7:33 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		23. HOUR	
MALE	WHITE	11/10/12		68 YRS.						8/7/81		7:33 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Conn.,		USA		WIDOWED		DIVORCED		ANNE ARUNDEL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
ANNAPOLIS		ANNE ARUNDEL GEN'L HOSP.		Retired		Post Office							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		A.A.		EDGEWATER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		886 Severn Ave., Edgewater, Md.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Frederick		Ida											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		578-05-2533		Lily E. Fallon-wife-(same as 13e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF							
4029				Asphyxiation P.V.B.									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		M.D. E. L. H. B. A. R. D. S.		DATE SIGNED 8-5-81					
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
E. L. H. B. A. R. D. S.		E. L. H. B. A. R. D. S.		Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		8-11-1981		Gate of Heaven		Sil. Spr. Montgomery, Md.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. DATE REC'D. BY REGISTRAR									
E. Pumphrey, Inc.		AUG 11 1981											
8434 Ga. Ave., S.S. Md.													

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19813	
1. DECEASED NAME (TYPE OR PRINT) <b>APPOLONE B. FISCHER</b>						2a. DATE KNOWN OF DEATH <b>8-2-81</b>		2b. HOUR <b>P</b>			
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>3</b> YEAR <b>09</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>71</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	7c. DATE PRONOUNCED DEAD <b>8-2-81</b>		7d. HOUR <b>P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>M.A.CO-GLEN BURNIE MD.</b>					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL Hosp. #2</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK (Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>OHIO</b>		13c. CITY OR TOWN <b>CLERMONT</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2093 HARKERWATTS Rd.</b>					
14. FATHER'S NAME FIRST <b>FRANK</b> MIDDLE <b></b> LAST <b>SANDKER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Josephine</b> MIDDLE <b></b> LAST <b>LITTEMEYER</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>					
16a. SOCIAL SECURITY NO. <b>217-56-3628</b>			17. INFORMANT (Daughter) <b>MARY J. BLAHA</b>			ADDRESS <b>233 ARUNDEL Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Disease</b> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <b>1 hour</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linhardt MD</b>				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>8-3-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>				ADDRESS <b>Annapolis, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-7-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S Cemetery</b>		23d. LOCATION CITY OR TOWN <b>CINCINNATI</b> COUNTY <b>HAMILTON</b> STATE <b>OHIO</b>					
24. FUNERAL DIRECTOR NAME <b>E. BARNES</b> ADDRESS <b>Fleming Funeral Service Benson, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8119814	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HENRIETTA M. FISCHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 31 81</b>		2b. HOUR <b>10:35 AM</b>
3. SEX <b>F</b>	4. RACE <b>C</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 5 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Austria</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel City MD.</b>	
10. CITY OR TOWN OF DEATH <b>HARWOOD</b>	11. NAME OF HOSPITAL, NURSING HOME OR INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brascears Nursing Home</b>		12a. USUAL OCCUPATION (OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		
13c. CITY OR TOWN <b>ANNE ARUNDIS</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME MIDDLE LAST <b>Ernest Smec, Sr.</b>			15. MOTHER'S MAIDEN NAME <b>Amelia Cihal</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-28-6409</b>		17. INFORMANT ADDRESS <b>Thelma Hunt, same as 13 a-e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE TO <b>4149 Chronic Congestive Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10+ years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years - 10+ years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Heartblock &amp; Pacemaker</b>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Present</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-21-1981</b> to <b>Present</b> , that (I) (we) lost saw the deceased alive on <b>8-21-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Peter F. Verkouw M.D.</b>				22c. DATE SIGNED <b>8/31/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER F. VERKOUW, M.D.</b>				22e. ADDRESS <b>1419 Forest Drive, Annapolis, Md 21403</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>9-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memo/Park</b>	
23d. LOCATION <b>Glen Burnie, Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 3 1981</b>			
24. FUNERAL DIRECTOR <b>Beall Funeral Home, 1212 West Street, Annp., Md.</b>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 1 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

E.D.T.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT J. FRANCHAK			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 20, 1981		2b. HOUR 2:05 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-6-1937		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cedex Public Acct.	
13a. STATE MD.			13b. COUNTY A.A.	13c. CITY OR TOWN Severna Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Franchak			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Pernick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 8-29-55-9-22-81 379-36-8880		17. INFORMANT ADDRESS Dorothy J. Franchak - Sec 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 4360 IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) G.I. Bleeding, shock (Esophageal Varices) DUE TO, OR AS A CONSEQUENCE OF (c) Liver cirrhosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 7/7/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Esophageal Varices		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur Gudwin M.D.		DEGREE M.D.		22c. DATE SIGNED 9/20/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR GUDWIN M.D.		22e. ADDRESS EMPIRE TOWERS, SUITE 500 7300 RITCHIE HIGHWAY, GLEN BURNIE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-24-81	23c. NAME OF CEMETERY OR CREMATORY Maryland Vet Cen. Crownsville		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. MD.	21061
24. FUNERAL DIRECTOR NAME Robert S. Barranco		ADDRESS 501 Ritchie Hwy. Severna Park MD.		25a. DATE REC'D. BY REGISTRAR AUG 24 1981	25b. REGISTRAR'S SIGNATURE Thom J. [Signature]

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified of a death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

BP \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 1 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>R HUDELL</b>		FIRST <b>G ARBER</b>		LAST <b>G ARBER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8/20/81</b>		2b. HOUR <b>1:30 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 12 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Arnold</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NANCC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>HA</b>		13c. CITY OR TOWN <b>Arnold</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>168 Severn Way</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ira Garber</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl M. Burrier</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-16-2422</b>		17. INFORMANT ADDRESS <b>Mr. William Garber</b>				<b>Arnold, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>dehydration</b> <b>3320</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Parkinson's disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3 July</b> 19 <b>81</b> , to <b>20 Aug</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>17 August</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Loraine M. Dailey MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8-20-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>8667 FT SMALLWOOD RD PASADENA MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/20/81</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1981</b>			
				25b. REGISTRAR'S SIGNATURE <i>Frank J. [Signature]</i>					

MEDICAL CERTIFICATION



51003A

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2005 年 12 月 1 日



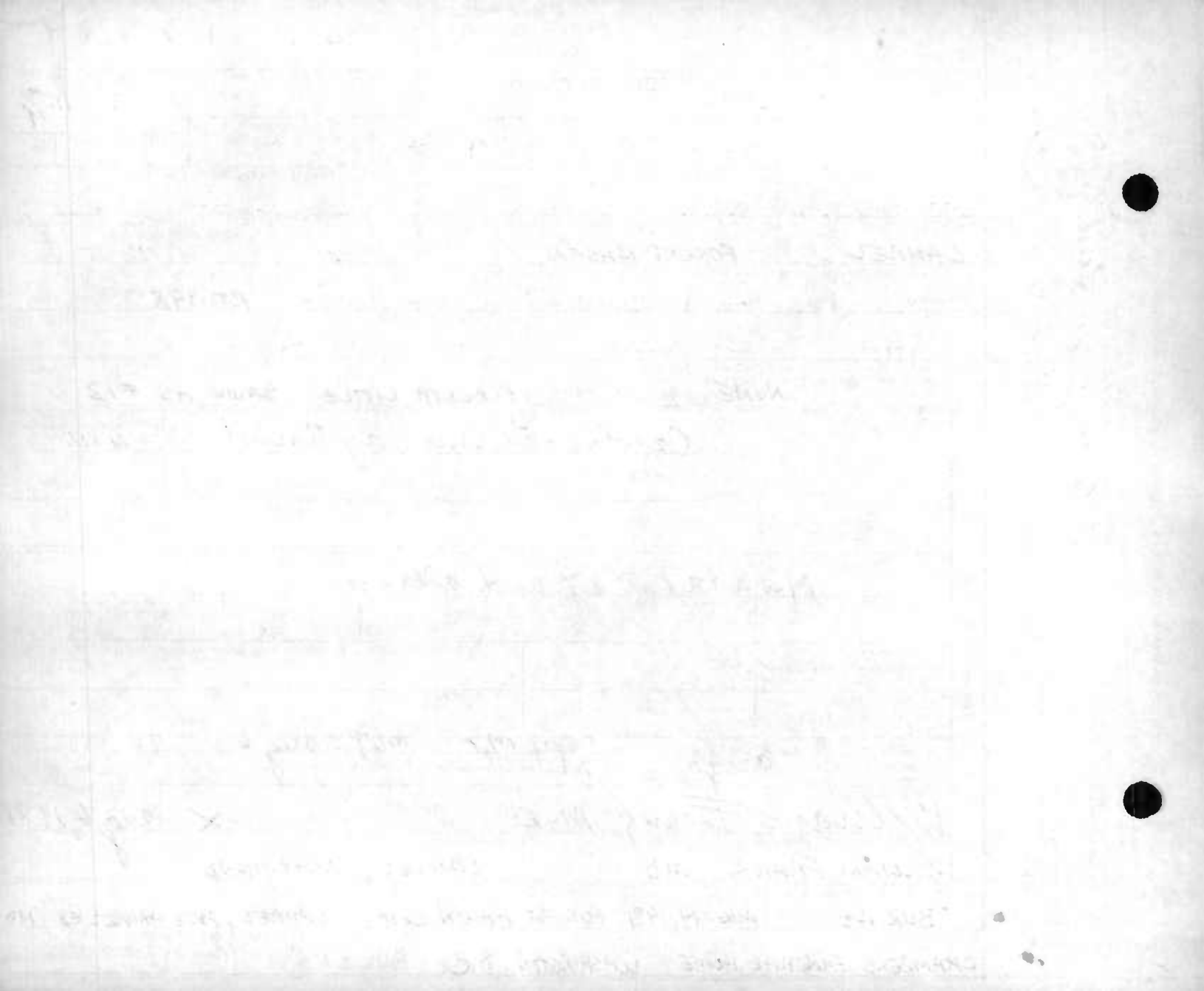
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed within 10 days in the files of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 1 1 9 8 1 7							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MICHAEL GASTON								08 05 81	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
MALE		Black		07 31 54		27		11:00 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U.S.A.				Anne Arundel		MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
LAUREL		FOREST HAVEN		N/A		N/A			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		Anne Arundel		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Billie James Gaston		Ida J. Taylor		NO		NONE 220-84-6368		ROBERTA LITTLE SAME AS #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4275								3 MIN.	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Mental Retardation</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1967</u> to <u>Aug 6, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug 5, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
William Frank, M.D.						Aug 6, 1981			
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
William Frank, MD		LAUREL, MARYLAND		FOREST HAVEN CEM.		LAUREL, ANNE ARUNDEL CO., MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		AUG. 14, 1981		FOREST HAVEN CEM.		LAUREL, ANNE ARUNDEL CO., MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
CHAMBERS FUNERAL HOME		WASHINGTON, D.C.		AUG 17 1981					





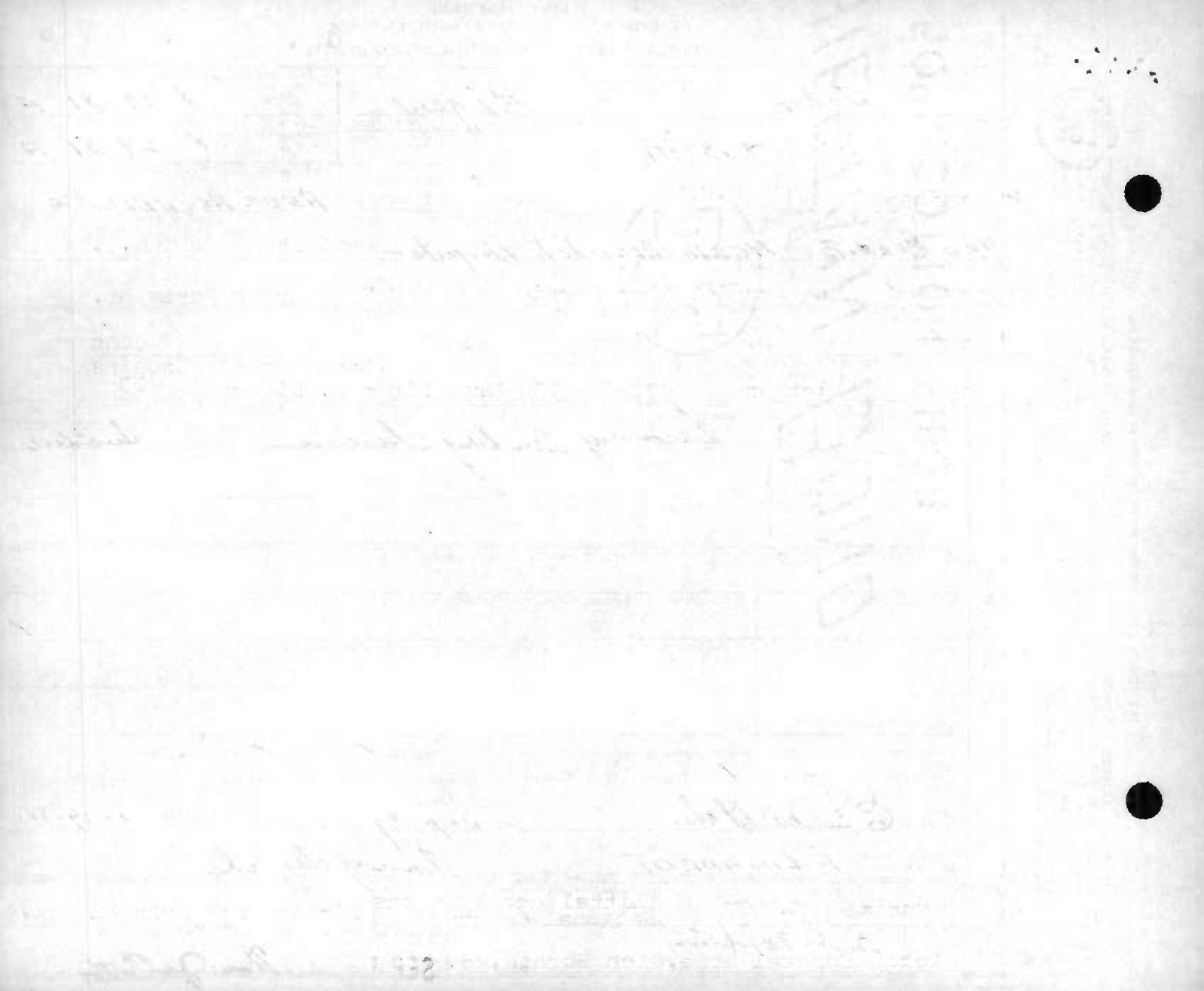
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1981	
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN ROBERT GIGER</b>					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		2b. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		2c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 1981		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		7. UNDER 24 HRS. MONTH <input type="checkbox"/> DAY <input type="checkbox"/> HOUR <input type="checkbox"/> MIN.		7d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO MD.		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst			12b. KIND OF BUSINESS OR INDUSTRY N.S.A.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James D. Giger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aleene Johnson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 432-68-0134		
17. INFORMANT (Wife) ADDRESS Same as #13			17. INFORMANT (Wife) ADDRESS Same as #13			17. INFORMANT (Wife) ADDRESS Same as #13			17. INFORMANT (Wife) ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>E. Linhardt</u>				TITLE (SPECIFY) M.D. <u>Deputy</u> MEDICAL EXAMINER				DATE SIGNED <u>5-29-81</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>F. LINHARDT</u>				ADDRESS <u>Annapolis, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/2/81				23c. NAME OF CEMETERY OR CREMATORY Little Rock Arkansas National Cemetery			
23d. LOCATION CITY OR TOWN COUNTY STATE Little Rock Pulaski Ark.				23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			
24. FUNERAL DIRECTOR NAME <u>R. N. Hopkins</u> ADDRESS Singleton Funeral Home, Glen Burnie, Md.											

SEP 1 1981



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19819	
1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD W GILBERT</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY 19 YEAR 1981	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Feb. 2, 1919</b>	6. AGE (IN YEARS) <b>62</b>	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <b>AUGUST 8, 1981</b>		2d. HOUR <b>3:45</b> M <b>P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter (ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Odenton</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>1426 Hale Street</b>			
14. FATHER'S NAME <b>Joseph Gilbert</b>				15. MOTHER'S MAIDEN NAME <b>Nettie Wilson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes-WWII</b>		16b. SOCIAL SECURITY NO. <b>294-10-5980</b>		17. INFORMANT (brother) ADDRESS <b>Harold Gilbert - Mineral Ridge, Ohio</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>MYOCARDIAL INFARCTION</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Richard E. Cook</b>				TITLE (SPECIFY) <b>Substitute</b>				DATE SIGNED <b>8/8/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>RICHARD E. COOK, M.D.</b>				ADDRESS <b>113 CATHEDRAL STREET, ANNAPOLIS, MD. 21401</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/12/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kerrs Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY <b>Weathersfield Twsp Ohio</b>			
24. FUNERAL DIRECTOR NAME <b>E. Barnes</b> ADDRESS <b>Fleming Funeral Service- Benson, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>				25b. NAME OF REGISTRAR <b>James J. Hatcher</b>			

WILLIAM A. JONES

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 1 1 9 8 2 0  
DST1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD H. GILNER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 18, 1981		2b. HOUR 1:15P M
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 18, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATCHMAN	12b. KIND OF BUSINESS OR INDUSTRY WATERFRONT	
13a. STATE NEW YORK			13b. CITY OR TOWN BROOKLYN	13c. STREET ADDRESS 1044 E. 9th St. Bklyn, N.Y.	
14. FATHER'S NAME MOSES GILNER			15. MOTHER'S MAIDEN NAME JENNIE SOKOLOFF		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 133-05-2998	17 INFORMANT ADDRESS DR. ABRAHAM GILNER 1044 E. 9th St. (11230) BROOKLYN N.Y.		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory Arrest</i> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Chronic Arrhythmia</i> (c) <i>Chronic Atrial Fibrillation, Rhythmic disorder</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *Chronic Atrial Fibrillation, Rhythmic disorder*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Jose m. Presbitero, m.d.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSE PRESBITERO M.D.		22e. ADDRESS 325 HOSPITAL DR. GLEN BURNIE, MD. 21061	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE Aug. 20, 1981	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN, N.Y.
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS		6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)	25a. DATE REC'D. BY REGISTRAR AUG 19 1981

71

UNITED STATES

DEPARTMENT OF THE ARMY

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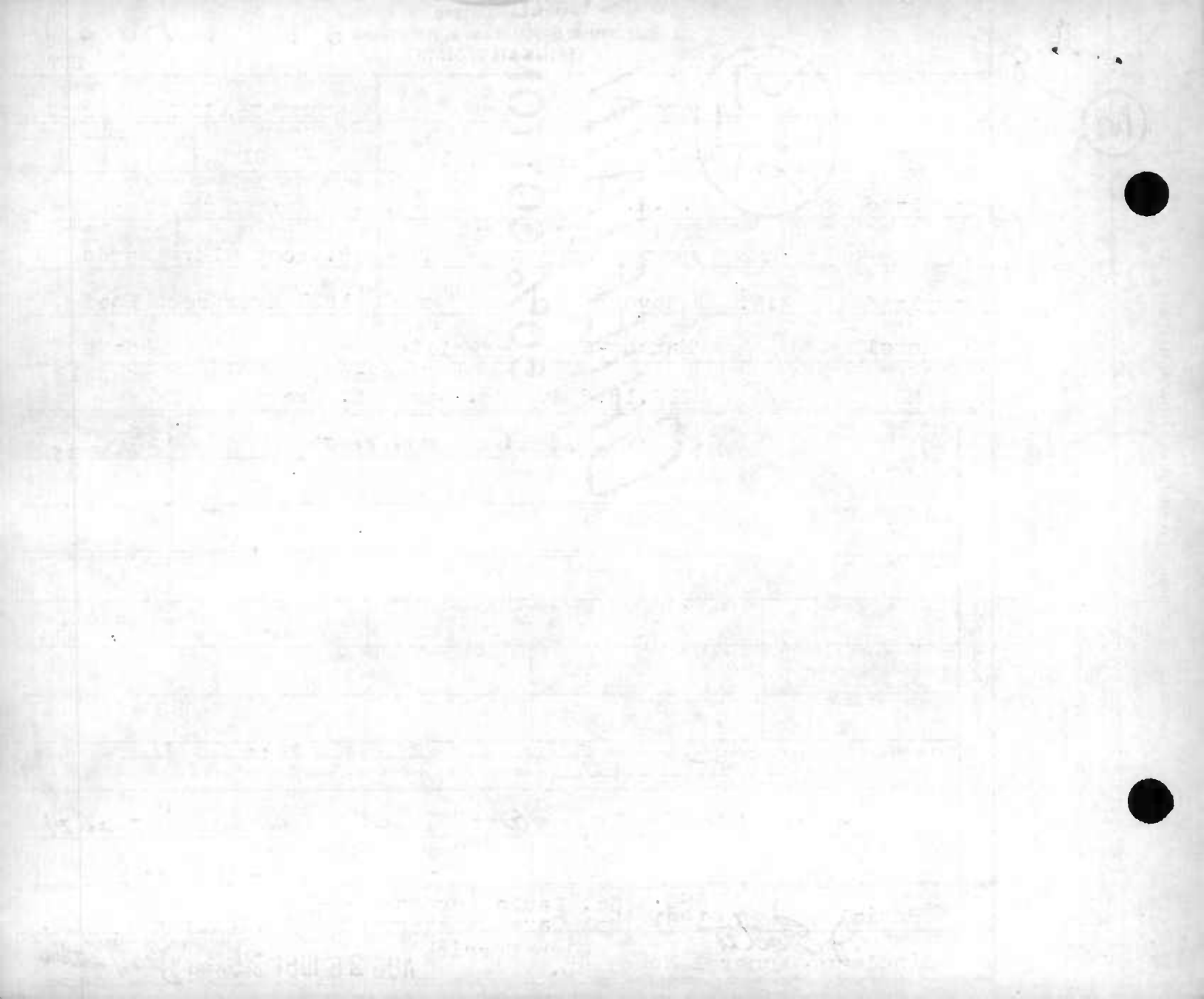
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LELA VIRGINIA GRAVES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 25, 1981</b>		2b. HOUR P M <b>3:30 P</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 21, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>81</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>81</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
13. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				15a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Stock Clk.</b>		15b. KIND OF BUSINESS OR INDUSTRY <b>Wards</b>			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>						16b. COUNTY <b>A.A.</b>		16c. CITY OR TOWN <b>Seyern</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>Rebell Matthews</b>						18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Adams</b>					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		20. INFORMANT (Husband) ADDRESS <b>Mr. James B. Graves</b>		21. Same as # 13					
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a	
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED				24a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		26c. LOCATION STREET CITY OR TOWN COUNTY STATE							
27. I certify that (I) (this hospital) attended the deceased from <b>8-23</b> , 19 <b>81</b> , to <b>8-25</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>8-25</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
28a. SIGNATURE <b>Sang C. DoH, M.D.</b>				28b. DEGREE <b>MD</b>				28c. DATE SIGNED <b>8-26-81</b>			
28d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SANG C. DOH, M.D.</b>				28e. ADDRESS <b>95 Aquahart Road Glen Burnie, Maryland 21061</b>							
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		29b. DATE <b>Aug. 28, 1981</b>		29c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Perpet-Marion ual Care Cemetery Station, Somerset, MD.</b>				29d. LOCATION CITY OR TOWN COUNTY STATE			
30. FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>				30a. ADDRESS <b>Glen Burnie, MD.</b>				30b. DATE REC'D. BY REGISTRAR <b>AUG 28 1981</b>			
30c. REGISTRAR'S SIGNATURE <b>James Van Natten</b>				30d. REGISTRAR'S SIGNATURE <b>James Van Natten</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 9 8 2 2	
FOR 1 - STATE REGISTRAR			CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
ARTHUR GORDON GRIFFITH					AUGUST 17, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)
Male		White		Feb. 16, 1907		74 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.
Maryland		U.S.A.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Track Foreman		Penn. R.R.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland			Arundel		Harmans	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Columbus Boone Griffith			Sarah Agatha Shipley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT (wife) ADDRESS	
No			N/A		Mrs. Louise S. Griffith # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic obstructive pulmonary disease</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 7, 1981</u> to <u>Aug. 17, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug. 17, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
<u>Antonio O. Gatdula M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>Aug. 18, 1981</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
ANTONIO O. GATDULA, M.D.		300 HOSPITAL DRIVE GLEN BURNIE, MD. 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		8/20/81		Friendship Cem.		Hanover, A.A. Maryland
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<u>R. M. Haychain</u>				AUG 20 1981		<u>Anna J. ...</u>
Singleton Funeral Home, Glen Burnie, Md.						

BP

Chas. H. Johnson, President  
of the  
Board of Directors  
of the  
American  
Telephone  
and  
Telegraph  
Company

August 17, 1887  
New York

Item 22A For M.E. 8/25/81 PT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19823	
FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph S Grube</i>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>8 22 19 51</i>		2b. HOUR AM PM <i>AM</i>			
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 22 60</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>20 YRS.</i>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>8 22 19 51</i>		7d. HOUR AM PM <i>AM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>P. A. CO.</i>					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sheet Metal</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Local Union</i>			
13a. STATE <i>MD.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1123 Riverbay Rd.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph C. Grube</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mildred R. Berger</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>216-76-5712</i>		17. INFORMANT ADDRESS <i>Joseph C. Grube - Sec. 13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Surgery to treat testicular tumor</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>9/20</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <i>5 22 19 51</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>assaulted to swallow fish</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Highway</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Route 50 Annapolis P.A. CO MD</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. Linhardt</i>				TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER				DATE SIGNED <i>8.22.51</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>E. Linhardt</i>				ADDRESS <i>Annapolis, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-25-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie P.A. CO MD</i>			
24. FUNERAL DIRECTOR NAME <i>Robert J. Barranco</i>				ADDRESS <i>501 Ritchie Hwy Severna Park MD</i>		25a. DATE <i>AUG 25 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

4

Table

Table 2

1-2632156

Table 3

Table 4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Request may be initiated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, only injury, or other traumatic event, the medical examiner must be notified of such.

Item #1 Film G559 9/4/81 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Preston Robert H. HADLEY, Jr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>August 22, 1981</b>		2b. HOUR <b>7:30 A.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 5, 1912</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vermont</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b>		MD.	
10 CITY OR TOWN OF DEATH <b>Crofton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1526 Ellsworth Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Naval Architect</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Crofton</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Preston H. Hadley</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Berry</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>066-10-2892</b>		17 INFORMANT ADDRESS <b>Crofton, Md.</b>		17b. NAME AND ADDRESS <b>Ruth M. Hadley, 1526 Ellsworth Ave.,</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>3352</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Boils</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3d</b> <b>3 mo</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/16</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from <b>8/21</b> , 19 <b>81</b> , to <b>8/22</b> , 19 <b>81</b> , and that (b) (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) did not view the body after death.					
22b. SIGNATURE <b>Robert Batsleer</b>				22c. DATE SIGNED <b>Aug. 22, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Batsleer, M.D.</b>				22e. ADDRESS <b>1438 Defense Highway, Gambrills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/25/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westfield, New Jersey</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Beall Funeral Home 16000 Annapolis Rd., Bowie, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Shane J. Norton</b>			

BP



152-4



no 066-10-2892 Ruth M. Hanley, 1226 Ellsworth Ave.,  
Crofton, Md.  
Preston H. Hanley Hazel Betty  
Maryland A.A. Crofton 1226 Ellsworth Avenue  
Crofton 1226 Ellsworth Avenue  
Retired Naval Architect  
Vermont U.S.A. Anne Almond  
Male Counc. Dec. 2, 1912 68  
B. HADLEY, Jr. August 22, 1901 7:30 A

8-111 8-25/1981 Folview Cemetery Westfield, New Jersey  
Robert Batscher, N.E. 1438 Deane Highway, Campbell, Md.  
1521 8-16 37 8-22 81

10000 Annapolis, Md. 8-111 8-25/1981 Folview Cemetery Westfield, New Jersey  
Best Funeral Home  
August 22, 1901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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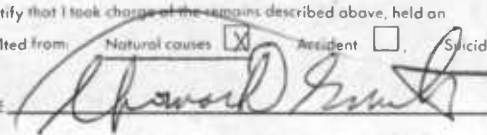

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

19825

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert J Hahn			2a. DATE KNOWN OF DEATH ESTIMATED 8 7 19 81			2b. HOUR 8:16 A.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 19 23	6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 8 7 19 81	2d. HOUR A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly Line		12b. KIND OF BUSINESS OR INDUSTRY Bendix	
13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 5203 Wasena Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Robert B. Hahn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve Carrado				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 217-12-0696		17. INFORMANT ADDRESS Genevieve Ballinger, Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 8/8/81		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn Street, Baltimore, MD. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/10/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk A.A. Md		
24. FUNERAL DIRECTOR NAME George J. Gonce				ADDRESS 4001 Ritchie Hwy.		25a. DATE REC'D. BY REGISTRAR AUG 10 1981		25b. REGISTRAR 



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 9 8 2 6			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST Edyth MIDDLE Mariam LAST HARRIS Edyth MARIAM Harris				2a. DATE OF DEATH MONTH DAY YEAR 8 4 '81		2b. HOUR M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 23, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Manor Nurs. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist		12b. KIND OF BUSINESS OR INDUSTRY Office Medical -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Anne Arundel 13c CITY OR TOWN Glen Burnie				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1002 Langley Road	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph O'Brennan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Bashman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO N/A		17. INFORMANT Mrs. Jacquelyn Thomas (Daughter)		ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3320 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 7-25-81 to 8-4-81, that (1) (we) lost the deceased alive on 8-4-81, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated (2) (did) (did not) view the body after death.							
22b. SIGNATURE MD				DEGREE MD		22c. DATE SIGNED 8-4-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M B BARUM				22e. ADDRESS 5800 old cent rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6 AUG '81		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD.				25. DATE REC'D. BY REGISTRAR AUG 6 1981		25b. REGISTRAR'S SIGNATURE Anne J. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

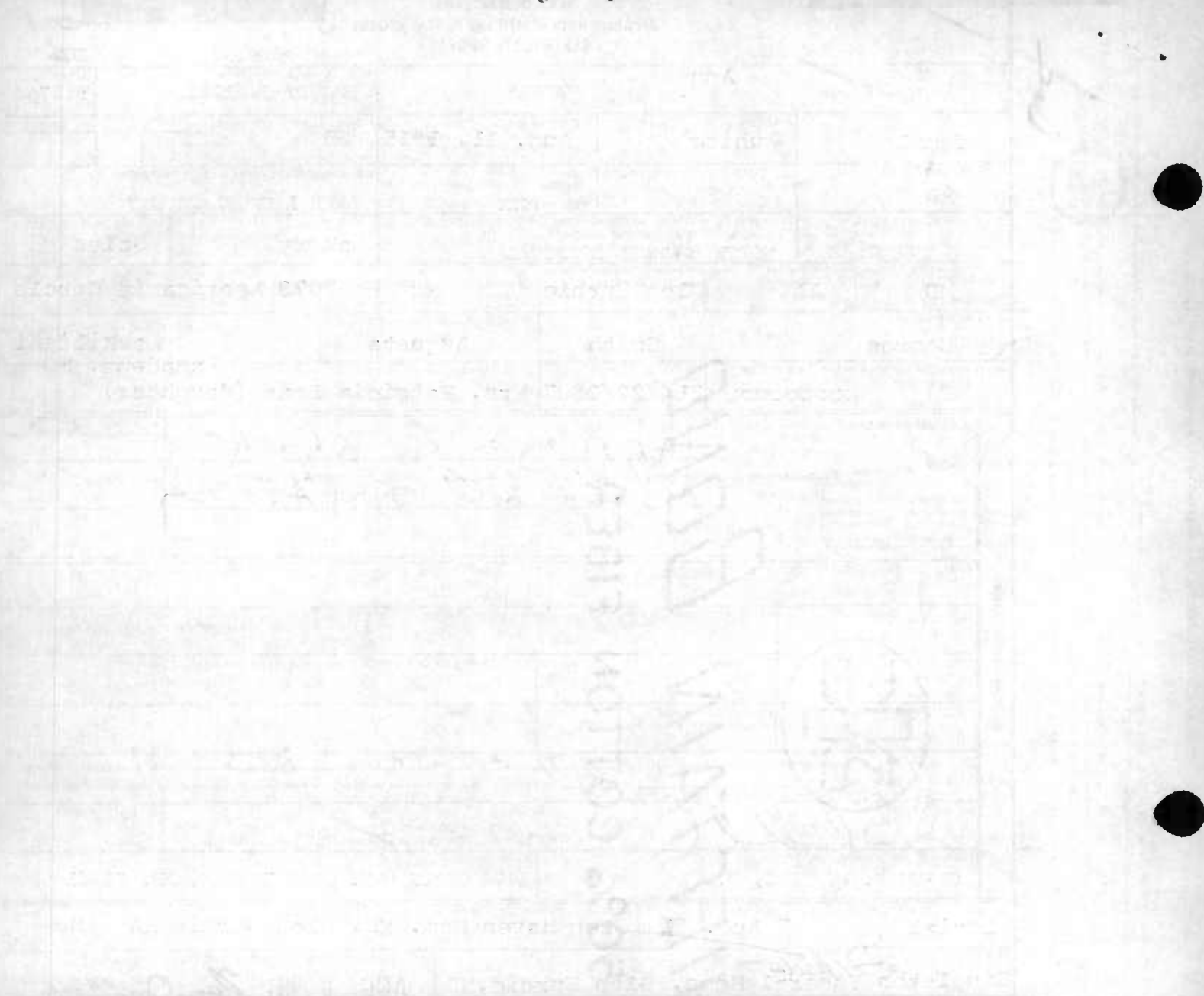
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3119827

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORA Ann A. HARVEY		AUGUST 3, 1981		9:27P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
female	white	Aug. 11, 1915	65	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH			
MD	ANNE ARUNDEL COUNTY MD	GLEN BURNIE			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
NORTH ARUNDEL HOSPITAL	Bakery	Sales			
13a. STATE	13b. CITY OR TOWN	13c. STREET ADDRESS	13d. INSIDE CITY LIMITS?		
MD	AA	Glen Burnie	YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			
George Smith	Augusta Lawkilishi	NO (IF YES, GIVE WAR OR DATES) xxxxxxxx			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
214/22/2807	Mrs. Patricia Bean (daughter)	Pasadena, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4100 CAR Diogenic Shock					
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial INFARCTION					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/7/80, 19 81 to 8/3, 19 81, that (I) (we) last saw the deceased alive on 8/3, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did, did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
GLENN F. ROBBINS, M.D.	M.D.				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
GLENN F. ROBBINS, M.D.	1404 CRAIN HWY. GLEN BURNIE, MD. 21061				
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	7 Aug. 81	Glen Haven Mem. PK.	Glen Burnie AA MD		
24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Singleton Funeral Home, Glen Burnie, MD		AUG 6 1981		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

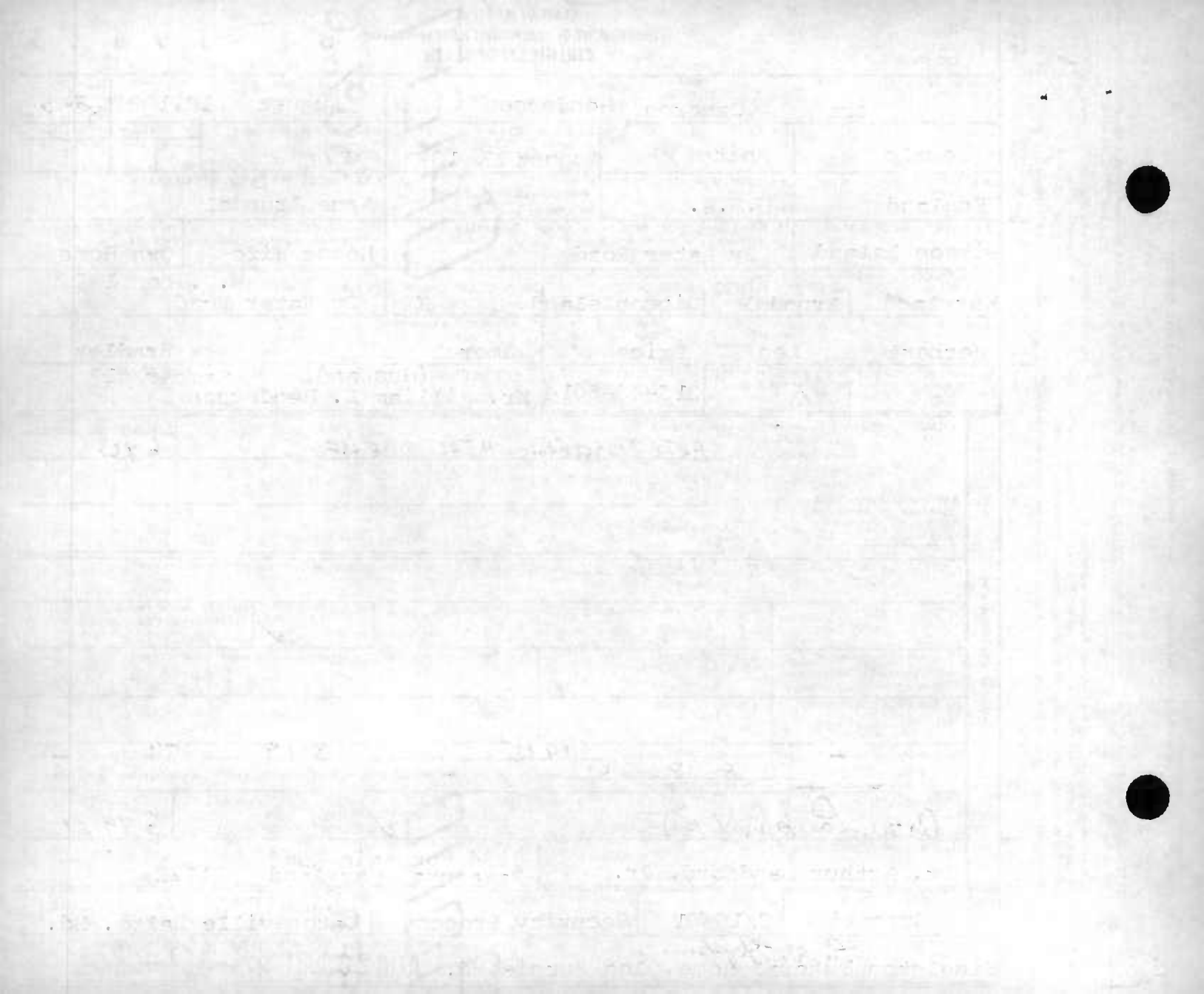
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 333-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 8 2 8			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Vera		Cameron		Henderson				August		18, 1981		8:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		August 23, 1893		87		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
England		U.S.A.				Anne Arundel						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Gibson Island		By Water Road		House Wife		Own Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Anne Arundel		Gibson Island		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 185					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Herbert		Lee		Price		Amoret		Bradley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) ADDRESS									
No		N/A		215-46-6014		Mr. William L. Henderson		Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 YRS.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <del>the</del> hospital attended the deceased from <u>1975</u> , 19 <u>81</u> , to <u>8-18</u> , 19 <u>81</u> , that (I) <del>was</del> last saw the deceased alive on <u>8-18</u> , 19 <u>81</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE		DEGREE								22c. DATE SIGNED			
<u>Arthur Landford, Jr. M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								<u>8-19-81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Dr. Arthur Landford, Jr.		2934 Mountain Road Pasadena, Maryland 21122											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Cremation		8/19/81		Security Process		Catonsville		Balto.		Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Singleton Funeral Home		R. M. Hopkins		AUG 20 1981		<u>Thomas J. ...</u>							

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DHMH-16 50M/7/77  
(VRA 15 (4))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 8 2 9			
2. CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>George N Henson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>08 20 81</b>				2b. HOUR <b>4<sup>12</sup> A M</b>			
3. SEX <b>MALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 14 47</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>ANNAPOLIS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>446 Broadneck Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE N. HENSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY E. FLEETWOOD</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>CHRISTINA HENSON 446 Broadneck Rd. Annapolis, Md. 21401</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>mins</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>7-30</b> , 19 <b>81</b> , to <b>8-20</b> , 19 <b>81</b> , that (b) (we) lost saw the deceased alive on <b>8-18</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ron Pickett</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-20-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD PICKETT</b>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>8-24-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HENSON CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Margarets A.A. Maryland</b>			
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				24a. ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8119830 E.D.T.	
1. FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) ROSS W. HOHMAN, SR.			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 24, 1981		2b. HOUR 0655 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 15, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager Tech. Serv. Maryland Cup		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Severna Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ross E. Hohman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie F. Kalk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-24-2462		17. INFORMANT ADDRESS Mary E. Hohman - Sec 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct. Sudden</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-20-81</u> to <u>8-24-81</u> , that (I) (we) lost <u>the deceased</u> above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jack I. Stern</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-24-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M. D.		22e. ADDRESS 300 HOSPITAL DRIVE, GLEN BURNIE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-81		23c. NAME OF CEMETERY OR CREMATORY Louden Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD.		23e. DATE REC'D. BY REGISTRAR AUG 26 1981			
24. FUNERAL DIRECTOR NAME Robert S. Barranco		24b. ADDRESS 501 Ritchie Hwy Severna Park MD			

BP

4

THE NATIONAL GALLERY

ONE PAIR OF SHOES

NO. 10

NO. 11

NO. 12

NO. 13

NO. 14

NO. 15

NO. 16

NO. 17

NO. 18

NO. 19

NO. 20

NO. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8119831 E.D.T.					
1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA DOROTHY HORVATH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 2, 1981</b>				2b. HOUR <b>7:11AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 31 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Linthicum Heights</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>6218 Woodland Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Grover C. Eney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Augusta Knopf</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-03-2021</b>		17. INFORMANT ADDRESS <b>Doris A. Leizear Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Recep Erol</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RECEP EROL, M.D.</b>				22e. ADDRESS <b>SUITE 104 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/5/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN <b>Wopdawn</b> COUNTY <b>Balto</b> STATE <b>Md</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke, P.A.</b> ADDRESS <b>1630 Edmondson Avenue Catonsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 3 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Martin</b>			

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(VRA 15, 4)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 9 8 3 2	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST MARY Frances HUGHES					MONTH DAY YEAR 8 29 81					6 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
Female		White		MONTH DAY YEAR June 16 1921		60 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Anne Arundel MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			19 E. Severn Ridge Rd			Retired			Banking		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MD			AA		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19 E. Severn Ridge Rd		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Raymond Edward Dove				Sarah Downey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS		
No				214-05-2548		Mrs. Murray Stewart			Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 Metastatic Colon CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from JUNE 24, 1980, to August 29, 1981, that (1) (we) lost saw the deceased alive on August 20, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (I) was (did) did not view the body after death.											
22b. SIGNATURE E. W. Cole III				DEGREE MD				22c. DATE SIGNED 8/31/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
ENSER W. COLE III				121 Cathedral St. Annapolis 21403							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Aug 31 1981		Cedar Bluff		Annapolis AA MD			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Taylor Funeral Chapel, Annapolis, MD								SEP 2 1981		Anne J. Martin	

BP \_\_\_\_\_

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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Female White June 18 1921  
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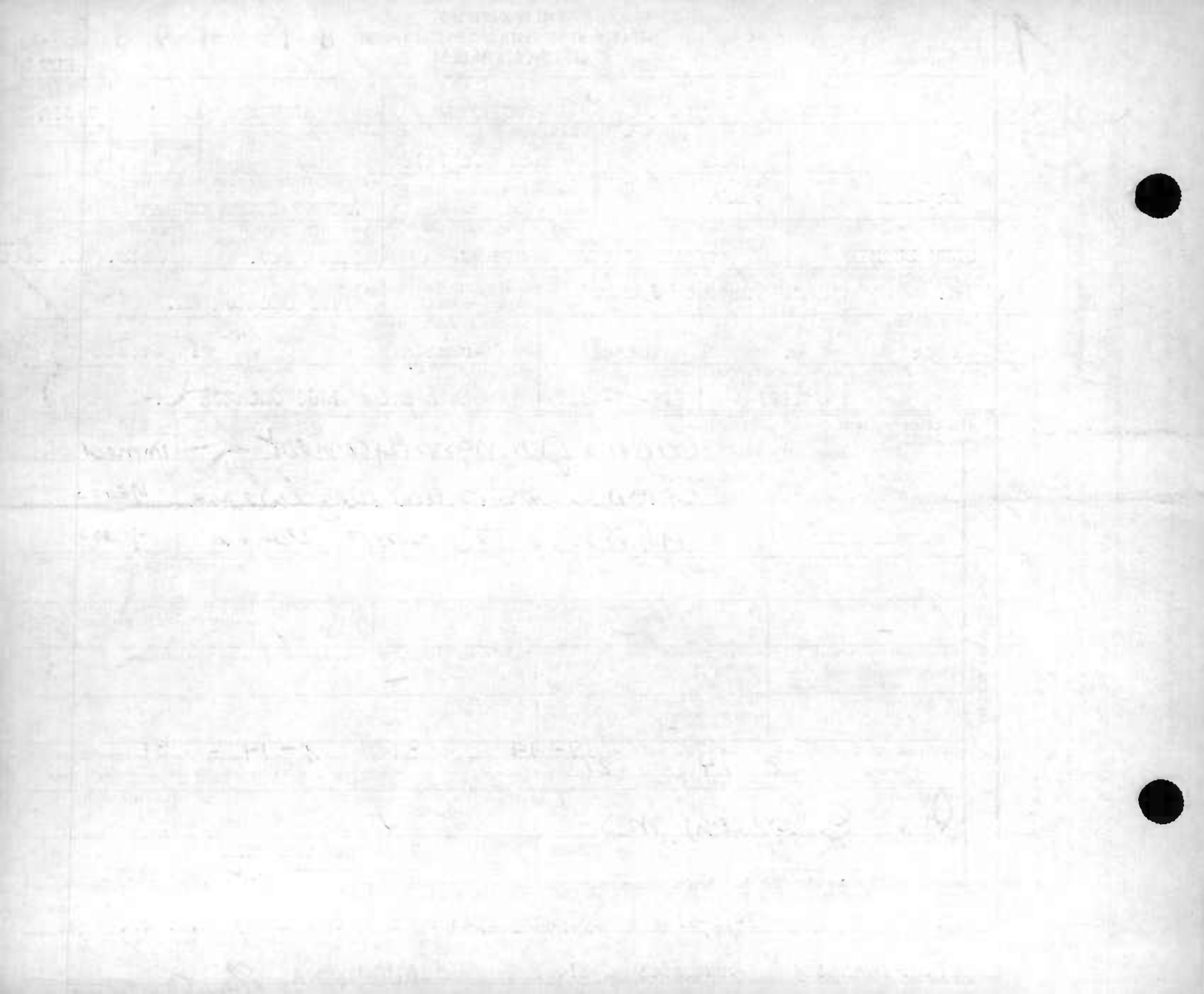
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	1	9	8	3	3
1. FOR STATE REGISTRAR		REG. NO.										EDT				
1. DECEASED NAME (TYPE OR PRINT) ROBERT W. INGERSOLL										2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15 1981		2b. HOUR 7:55A M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22 1912		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD										
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meter Div.		12b. KIND OF BUSINESS OR INDUSTRY Balto. Gas Elec								
13a. STATE Md.										13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton				
14. FATHER'S NAME FIRST MIDDLE LAST Robert G. Ingersoll		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Ingersoll														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT Roberta Brown		17. ADDRESS 1408 Odenton Rd.										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed. years years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:																
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>7-19</u> , 19 <u>81</u> , to <u>8-14</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8-14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Dr. E. Kaplan, MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED								
22b. PHYSICIAN'S NAME (TYPE OR PRINT) IRA E. KAPLAN, M.D.						22c. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-15-81		23c. NAME OF CEMETERY OR CREMATORY Epiphany Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE Odenton A.A. Co. Md										
24. FUNERAL DIRECTOR NAME T.A. Hardesty						ADDRESS Annapolis Md 21401		25a. DATE REC'D. BY REGISTRAR AUG 17 1981		25b. REGISTRAR'S SIGNATURE <u>Ann. O. M.</u>						

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 SOM 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 3 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Richard M Johnson</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>5</b> YEAR <b>81</b>		2b. HOUR <b>5<sup>10</sup> A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>5</b> DAY <b>18</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AA G.H. General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Company</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Anne</b>	13c. CITY OR TOWN <b>Edgewater</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4149 Cadle Creek Road,</b>	
14. FATHER'S NAME FIRST <b>Ebert</b> MIDDLE <b>H.</b> LAST <b>Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Effie</b> MIDDLE <b>Benton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Evelyn V. Johnson-wife-(same as 13e)</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/31</b> P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET <b>81</b> CITY OR TOWN <b>81</b> COUNTY <b>81</b> STATE <b>81</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/5</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Erner W. Cole III MD</b>		22c. DATE SIGNED <b>8/5/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ENSER W. COLE III</b>		22e. ADDRESS <b>121 CATHEDRAL ST ANNAP MD.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-7-1981</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Washington, DC</b> COUNTY <b>DC</b> STATE <b>DC</b>
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b> <b>8434 Ga. Ave., S.S. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>	25b. REGISTRAR'S SIGNATURE <i>Thane Jan. Heston</i>

Richard M. Johnson

Feb 18 03

Anne Johnson

Amherst



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

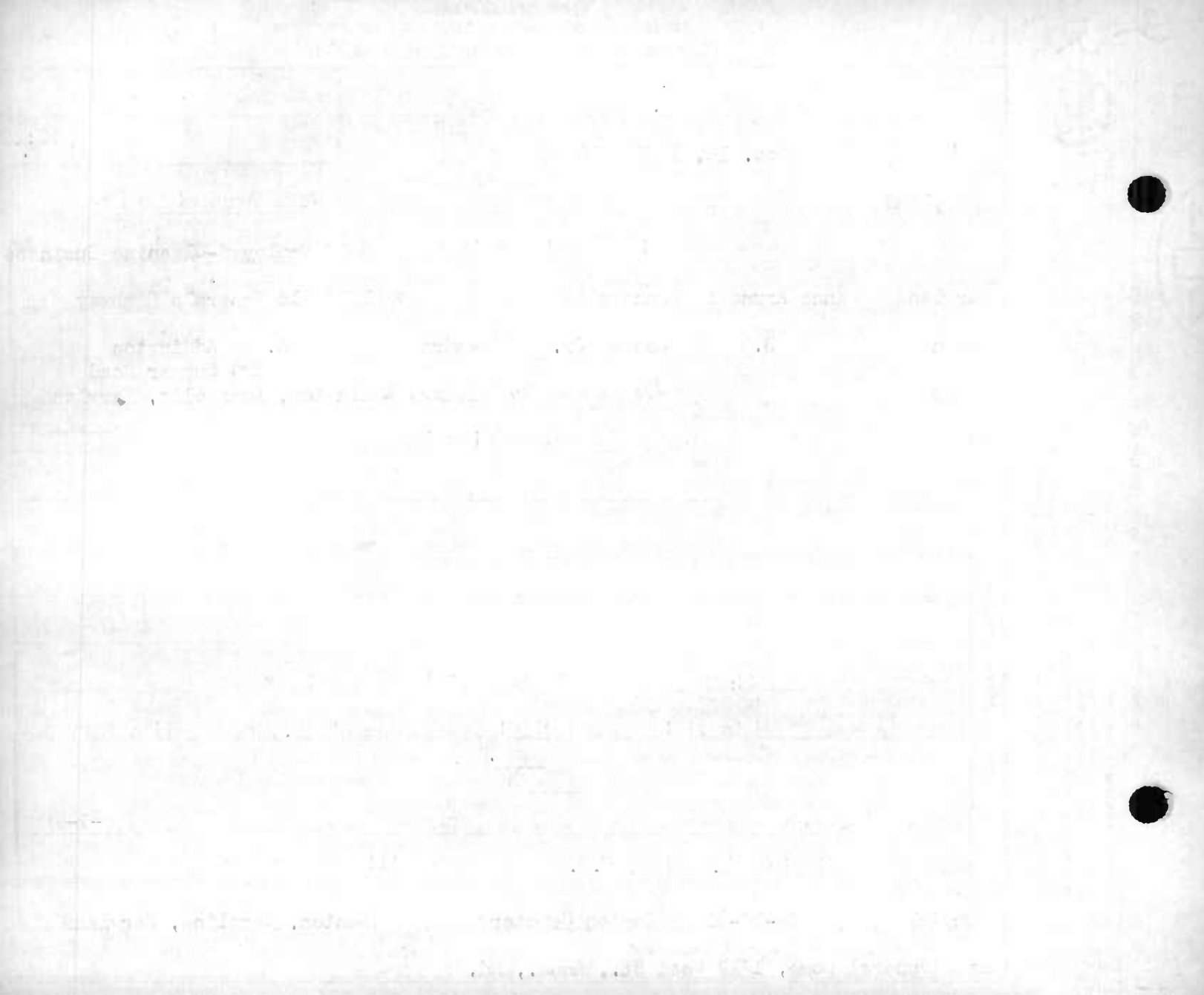
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Florence Cornelius JONES</u>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <u>8-24-81</u> <u>7:55 PM</u>					
3. SEX <u>Female</u>		4. RACE <u>BLACK</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>2</u> <u>3</u> <u>20</u>		6. AGE (IN YEARS LAST BIRTHDAY) MONTH DAYS HOURS MIN. <u>61</u> YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>ANNE ARUNDEL CO</u> MD.				
10. CITY OR TOWN OF DEATH <u>Lincolnton</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ANNE ARUNDEL General</u>				12a. USUAL OCCUPATION (TYPE OF WORK, STREET OR PORT OF CALL) <u>Custodial</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Md.</u>		13c. COUNTY <u>Annapolis</u>		13d. CITY OR TOWN <u>Annapolis</u>		13e. STREET ADDRESS <u>1155 Madison St - 54</u>				
14. FATHER'S NAME FIRST MIDDLE LAST <u>WILLIAM Dorsey</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ELSIE MARY JONES</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>215-12-5270</u>		17. INFORMANT <u>Robert A Beavers - 1412 14th Ave</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).	
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 5</u> , 19 <u>81</u> , to <u>Aug 24</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Aug 24</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Veita J. Bland MD</u>					DEGREE		22c. DATE SIGNED <u>8/28/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Veita J. Bland, MD</u>					22e. ADDRESS <u>111 Cathedral St Annapolis Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>8-29-81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PINE LAWN</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis AA Md</u>			
24. FUNERAL DIRECTOR <u>C. E. Hicks</u>					25a. DATE REC'D. BY REGISTRAR <u>SEP 01 1981</u>					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



## MEDICAL CERTIFICATION

DHMH - 17  
(VR A15 ME (5))  
15M2/80

BP.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MICHAEL H JONES</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8 9 1981			2b. HOUR <b>P</b>		
3. SEX <b>M</b>	4. RACE <b>N</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 23 73</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>78</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 8 10 1981	2d. HOUR <b>P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.C.O.</b>		
10. CITY OR TOWN OF DEATH <b>A.A.C.O.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SEVERN-RIVER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>GLEN BURNIE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>TERRY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ARLENE SNOWDEN</b>		13e. STREET ADDRESS <b>7807 Bruton Dr. Apt. C</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Glen Burnie, Md. ARLENE A. JONES 7807 Bruton Dr. Apt. C</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>(P.M.) 8 9 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Swimming, Severn River</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>SEVERN-RIVER</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Severn-River A.A.C.O. MD</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>E. Linhardt</b>		TITLE (SPECIFY) M.D. <b>Deputy</b>				DATE SIGNED <b>8-10-81</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>		ADDRESS <b>Annapolis, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-14-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1981</b>		
				25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>				

SECTION 1111.5

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH YOUR FILES, AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19838	
1. DECEASED NAME (TYPE OR PRINT) <b>TERRY R JONES</b>						2a. DATE KNOWN OF DEATH <b>8-9-81</b>		2b. MONTH <b>8</b> DAY <b>9</b> YEAR <b>1981</b>		2c. HOUR <b>7</b> AM	
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>9</b> YEAR <b>54</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>27</b> YRS.		IF UNDER 1 YR. MONTHS <b>27</b> DAYS <b>27</b> HOURS <b>27</b> MIN.		7c. DATE PRONOUNCED DEAD <b>8-10-81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.C.O.</b>	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SEVERN-RIVER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>GLEN BURNIE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7807 Bruton Dr. Apt. C</b>	
14. FATHER'S NAME FIRST <b>KENITH</b> MIDDLE <b>JONES</b>						15. MOTHER'S MAIDEN NAME FIRST <b>MARGIE</b> MIDDLE <b>WILLIAMS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>220-60-9688</b>		17. INFORMANT <b>ARLENE JONES</b> ADDRESS <b>Glen Burnie, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>9102</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sudden</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 8 9 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Drowning in Severn River</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>A.A.C.O. MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linhardt</b> M.D.				TITLE (SPECIFY) <b>MD</b>				DATE SIGNED <b>8-10-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>				ADDRESS <b>Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>				23b. DATE <b>8-14-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINELAWN MEM. PARK</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>William Reese &amp; Sons Mortuary, P.A.</b> ADDRESS <b>Annapolis, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. H. H.</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 9 8 3 9 REG. NO.				EDT			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST		2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR
MARGIE SOPHIE JURKEWITZ								AUGUST 26, 1981							11:45 P <sup>M</sup>
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS (LAST BIRTHDAY))				IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Jan. 19, 1901				80 YRS.				MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.						ANNE ARUNDEL COUNTY MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE				NORTH ARUNDEL HOSPITAL				Homemaker				Own Home			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland				A.A.		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7979 Nolcrest Road					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
James Fields				Virginia Hennenberger											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter)		ADDRESS Same as #13							
No				N/A		212.24.8848		Mrs. Margy E. Steinbock							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Smoking</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS <u>Contributing to death but not related to the terminal disease or condition given in Part 1:</u> <u>Arteriosclerotic heart disease</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19____, to <u>8/26</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/26/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>James Benjamin</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.														22e. ADDRESS 517 Empire Towers 7300 Ritchie Highway, Glen Burnie, M.D. 21061	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial				29, 1981		Loudon Pk. Cem.				Baltimore,				MD.	
24. FUNERAL DIRECTOR NAME <u>R. H. Hopkins</u> ADDRESS <u>Glen Burnie</u>				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Singleton Funeral Home MD.				AUG 28 1981				<u>Frances Jan Nathan</u>							

INVESTIGATION OF THE  
ACTS OF VIOLENCE

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and Charles ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by name.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 8 4 0	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>FRED</b>	MIDDLE <b>HENRY</b>	LAST <b>KAISS</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 6 1981</b>		2b. HOUR <b>6 56PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 9, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>80 YRS.</b>		7. IF UNDER 24 HRS. HOURS MIN. <b>80 YRS.</b>	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		8b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN (ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>715 GREENTREE ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY F. KAISS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE SCHWANTZBURG</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (WIFE) <b>MRS. PHYLLIS F. KAISS</b>		ADDRESS <b>SAME AS # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Coronary disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>June 5, 1980</b> to <b>Aug 6, 1981</b> , that (I) (we) last saw the deceased alive on <b>Aug 6, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel Rubinfeld</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8/8/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SAMUEL RUBIN</b>		22e. ADDRESS <b>1 SLADE AVENUE PIKESVILLE MARYLAND 21208</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10 AUG. 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A.A., MD.</b>					
24. FUNERAL DIRECTOR NAME <b>Don Y. Chilton</b> ADDRESS <b>Glen Burnie, Maryland</b>		24b. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>		24c. REGISTRAR'S SIGNATURE <b>Don Y. Chilton</b>							

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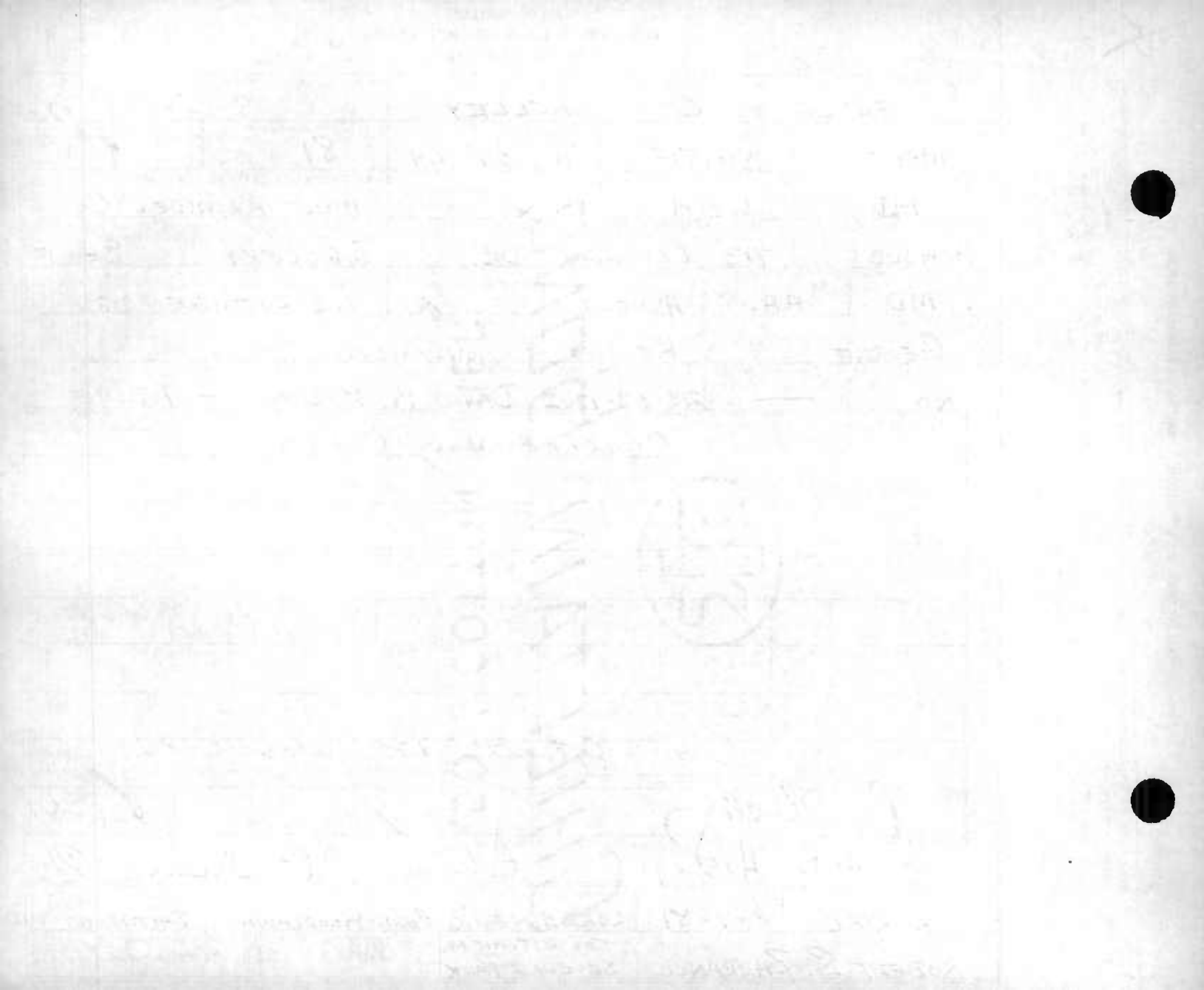
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8119841									
1. FOR STATE REGISTRAR		REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR						
EARLE		C		KELLEY				8-5-81					7:35 PM						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
MALE		WHITE		MONTH DAY YEAR 11 24 99		81		MONTHS DAYS		HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
MD		USA				ANNE ARUNDEL Co. MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
ARNOLD		713 COTTAGE DR.										GROCERY		SELF					
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MD										A.A.		ARNOLD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		713 COTTAGE DR.			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST GEORGE					FIRST MIDDLE LAST UNKNOWN														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17. INFORMANT ADDRESS									
NO					218-32-1702					DAVID W. KELLEY - ABOVE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) 1539 Carcinoma of Colon																			
DUE TO, OR AS A CONSEQUENCE OF (b)																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 23</u> , 19 <u>72</u> , to <u>Aug 5</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8-4</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE					DEGREE					22c. DATE SIGNED									
<u>D. H. Bishop</u>										8-6-81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS														
DONALD H. BISHOP					Robinson Rd - Severna Park														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL					8-7-81					LORRAINE PK. COM.					WOODLAWN BALTIMORE MD				
24. FUNERAL DIRECTOR NAME					ADDRESS					25a. DATE RECEIVED BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
ROBERT S. BARRANCO					501 RITCHIE HW SEVERNA PARK					AUG 10 1981					<u>James J. North</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR STATE REGISTRAR					8 1 1 9 8 4 2					
CERTIFICATE OF DEATH					REG. NO. EDT					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCES LUCILLE KENNEDY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 31, 1981</b>			2b. HOUR <b>3:20P<sub>M</sub></b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 1, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A.A. CO. FIRE DEPT.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>SEVERNA PK.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM M. CHELF</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY A. SCHONE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (SON) <b>MR. GERARD P. KENNEDY</b>		ADDRESS <b>3500 Park Lawn Ave. 21213</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Disseminated cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rebreast cancer</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>174-9</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8/3/81</u> 19 <u>81</u> to <u>Aug 31</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/3/81</u> 19 <u>81</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
22b. SIGNATURE <u>James J. Benjamin, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/1/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES J. BENJAMIN, M.D.</b>					22e. ADDRESS <b>7300 RITCHIE HWY. 21061 517 EMPIRE TOWERS, GLEN BURNIE, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/3/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>GLEN BURNIE, A.A., MD.</b>				
24. FUNERAL DIRECTOR NAME <b>R.H. Hopkins</b>		ADDRESS <b>Glen Burnie Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 1 1981</b>		25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>				

BP

111

45547 AUGUST 12, 1954

ADAMS AIRMAIL

DEAN BURNETT NORTH RUMBLE HOSPITAL

STANDARD

JAMES C. BURNETT, JR. 100 W. 10th St. S. MINNAPOLIS, MINN.

SEP 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 48 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>RICHARD WILLIAM KLEINEN SR.</b>			2a. DATE OF DEATH Month Day Year <b>8 24 81</b>			2b. HOUR M <b>8</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1919 DECEMBER 14,</b>		6. AGE (In years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Anne Arundel County</b> Md.	
10. CITY OR TOWN OF DEATH <b>Pasadena</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>East Home 7997 Riverside Dr</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dr. Stat. Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cork &amp; Seal</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>7997 E. Riverside Dr.</b>		14. FATHER'S NAME First Middle Last <b>Joseph Kleinen</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Jeanette Richart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217 09 7254</b>		17. INFORMANT Address <b>Mrs. Richard Kleinen same as 13 e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic heart disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>78</b> , to <b>8/25</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>8/23</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George J. Gonce</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/24/81</b>	
22d. PHYSICIAN'S NAME (Type) <b>George J. Gonce</b>		22e. ADDRESS <b>CHURCH</b>		22f. ADDRESS <b>8 EVERGREEN RD SEVERNA PARK</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>	

MEDICAL CERTIFICATION



REG. NO.

LAST

KRAUSE

1. *Abstract*

26. ROCK

9. BALTIMORE CITY OR COUNTY OF DEATH  
Baltimore, Maryland

12a. USUAL OCCUPATION (TYPE OF WORK)	12b. KIND OF BUSINESS
--------------------------------------	-----------------------

FOR MOST OF WORKING LIFE) OR INDUSTRY

**Manfg. Manager** **Manfg. Manager**

4/25/10	Manic: Manager	Kenleey
---------	----------------	---------

13a. STREET ADDRESS 416 D. Starwood Rd.

100

## Unknown

17. INFORMANT (Daughter) ADDRESS 434 Gatewood  
Mrs. Karen K. Salzman, Ct. 21061

Approximate Interval Between Onset and Diagnosis

May 1900	100
June 1900	100
July 1900	100
Aug 1900	100
Sept 1900	100
Oct 1900	100
Nov 1900	100
Dec 1900	100
Jan 1901	100
Feb 1901	100
Mar 1901	100
Apr 1901	100
May 1901	100
June 1901	100
July 1901	100
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Oct 1901	100
Nov 1901	100
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Mar 1911	100
Apr 1911	100
May 1911	100
June 1911	100
July 1911	100
Aug 1911	100
Sept 1911	100
Oct 1911	100
Nov 1911	100
Dec 1911	100
Jan 1912	100
Feb 1912	100
Mar 1912	100
Apr 1912	100
May 1912	100
June 1912	100

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

20. AUTOREVY

YES ☐ NO ☒

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21f LOCATION			
STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

TITLE (SPECIFY) \_\_\_\_\_ DATE \_\_\_\_\_  
M.D. Repe & g MEDICAL EXAMINER 8/24/81  
ADDRESS Imperial, Md

LOCATION  
CITY OR TOWN  
Salem, Va. COUNTY  
Belt STATE  
MD

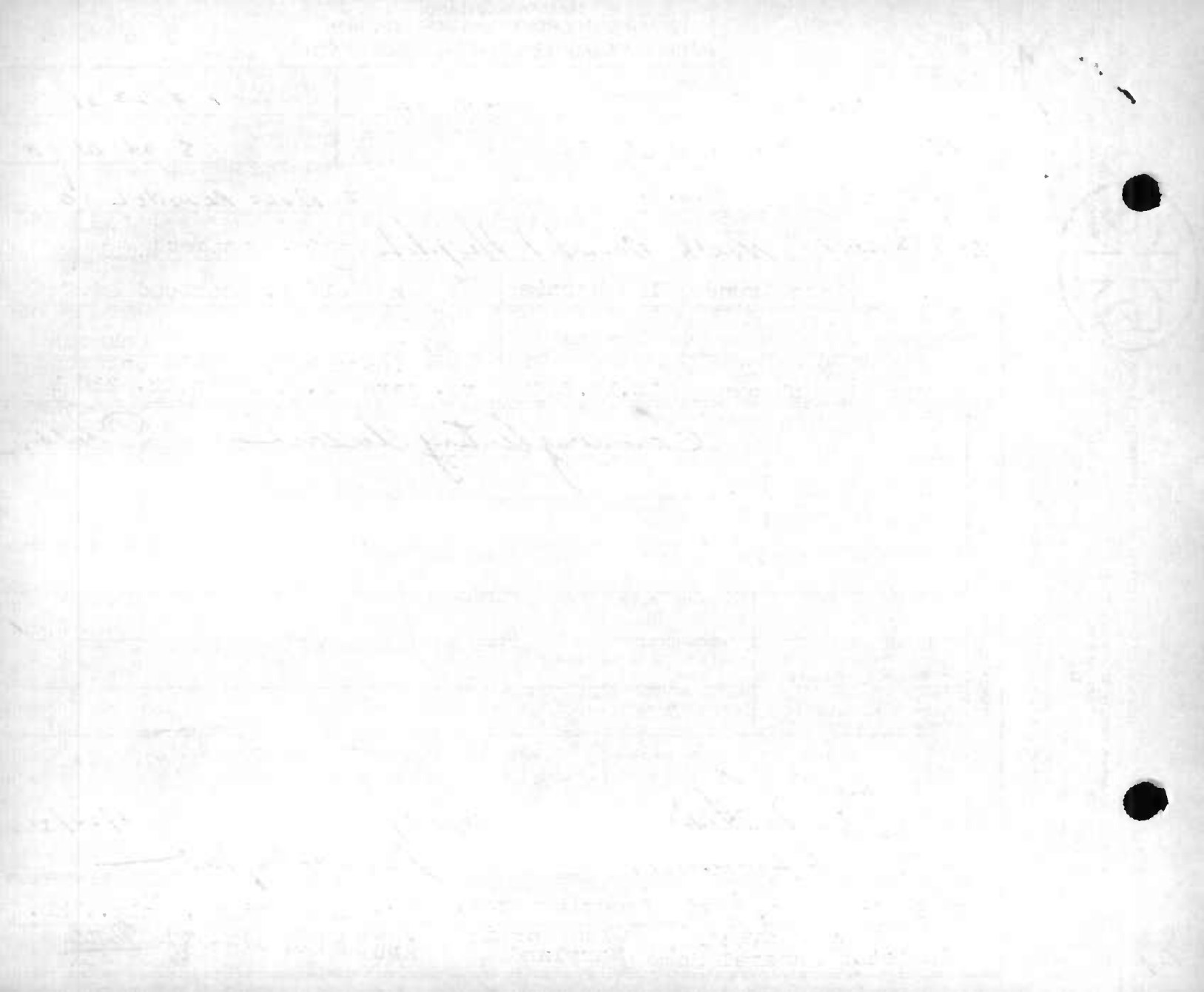
25a. DATE RECD. BY REGISTRAR **AUG 25 1981** REGISTRAR'S SIGNATURE *Francis J. [illegible]*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN COMPLETION OF THE CERTIFICATE IS ANTICIPATED, IT SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 4 AND 5, AND RETURN THEM TO THE CHIEF MEDICAL EXAMINER WITHIN 72 HOURS OF DEATH.

BP\_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M2/80



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 4 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Emma NMN KUEHN			2a. DATE OF DEATH MONTH DAY YEAR August 1, 1981			2b. HOUR 9:25 P <sub>M</sub>				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10 CITY OR TOWN OF DEATH Millersville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Knollwood Manor N/Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Tech.		12b. KIND OF BUSINESS OR INDUSTRY Dr. Office		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 554 Twin Oaks Road	
14 FATHER'S NAME FIRST MIDDLE LAST Christian Kuehn				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Kalb						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17 INFORMANT Nephew		ADDRESS Same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Decubitus Ulcer; Senile Dementia Alzheimer Type</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/14/76</u> , 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>July 31</u> , 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Paul Rhodes MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug 3, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Rhodes M.D.						22e. ADDRESS Crofton Med. Center, Crofton Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 4, 1981		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Luth Cen			23d. LOCATION CITY OR TOWN STATE Bart. Md.		
24. FUNERAL DIRECTOR NAME <u>H B Williams</u>						25a. DATE REC'D. BY REGISTRAR AUG 3 1981				
Singleton Funeral Home, Glen Burnie, Md.						25b. REGISTRAR'S SIGNATURE <u>James J. Harten</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 8 4 6	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO. E.D.T.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
ICLON		LEE		AUGUST 26, 1981	
3 SEX		4 RACE		5. DATE OF BIRTH	
Female		Black		MONTH DAY YEAR 1 7 03	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
N. Carolina		U.S.A.		78 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Maryland		A.A.		Rt. 9 Box 205 A	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Joseph Baker		Mary Baker		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA, PRIMARY UNKNOWN 1991 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS	
Alvah Odell Lee-same as above		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from MAY 23 19 81, to AUG 26 19 81, that (1) (we) last saw the deceased alive on AUG 26 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE Max Goodman MD		22c. DATE SIGNED AUG 27 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
MAXWELL GOODMAN, M.D.		104 FORBES STREET ANNAPOLIS, MARYLAND 21404			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-31-81		Md. Vet. Cem.	
24. FUNERAL DIRECTOR NAME ADDRESS		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
CHAS. A. RICE FSPA 1300 Eutaw Place		SEP 1 1981		[Signature]	



8.1.31

7:30PM

August 20, 1901

THE

ICION

33

7

1

Black

Female

WILL AMUNDEN CITY

... ..

WILL AMUNDEN HOSPITAL

CLERK

Box 202 A

... ..

... ..

Baker

... ..

Baker

Joseph

Alvin Odell loc-dance as above

... ..



104 RORER STREET  
ANNAPOLIS, MARYLAND 21404

MAXWELL GOODMAN, M.D.

... ..

... ..

... ..

... ..

SEP 1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILMA Stanley Lee			2a. DATE OF DEATH MONTH DAY YEAR 08 03 81			2b. HOUR 1245				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Swansboro, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co MD				
9. CITY OR TOWN OF DEATH Imperial		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner		12b. KIND OF BUSINESS OR INDUSTRY Restuarant		
13a. STATE Md			13b. COUNTY AA Co		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4085 Shoreham Beach Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST John Bryant Stanley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Elizabeth Glancy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW2 577 28 9005		17. INFORMANT ADDRESS Sean S. Harty, Columbia, S.C.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cerebral death Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral anoxia. DUE TO, OR AS A CONSEQUENCE OF (c) Cardio respiratory arrest PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 812 19 81 to 813 19 81, that (I) (we) last saw the deceased alive on 813 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE George C. Samaras					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/13/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras					22e. ADDRESS 1616 Forest Drive Anns. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-6-81		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va MD			
24. FUNERAL DIRECTOR NAME Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401					25a. DATE REC'D. BY REGISTRAR AUG 5 1981		25b. REGISTRAR'S SIGNATURE Thane J. [Signature]			

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Handwritten text, possibly a title or description, written in a cursive script. The text is mirrored across the page.

Handwritten text at the bottom of the page, including what appears to be a date and a signature or name. The text is mirrored across the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 9 8 4 8	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.		E.D.T.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA Leonelli				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 17, 1981				2b. HOUR 11:10 <sup>A</sup>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 22 <sup>nd</sup> 1893		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Arundel Glen Burnie				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Oakwood Road					
14. FATHER'S NAME (FIRST MIDDLE LAST) Louis Apicella				15. MOTHER'S MAIDEN NAME (MIDDLE LAST) Mary Dinnatasso							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 577 34 1926		17. INFORMANT ADDRESS Richard Monsolillo/nephew 3105 ElkrIDGE Ct Beltsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Antractable Congestive Heart failure months DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C. D.D. years DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-20-81 to 8-17-81, that (I) (we) last saw the deceased alive on 8-16-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE JACK I. STERN, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-17-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D.				22e. ADDRESS 300 HOSPITAL DRIVE, #135 GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-19-81		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.				11800 New Hampshire Ave Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR AUG 21 1981		25b. REGISTRAR'S SIGNATURE [Signature]	



11500 New Hampshire Ave  
Washington, D.C. 20004  
1-202-462-1000



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leona Van Rie Liddy			2a. DATE OF DEATH MONTH DAY YEAR Aug. 15, 1981		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mishawaka, Ind.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) social worker Dept. of Soc. Serv.	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland.	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Churchton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5718 Bay View Pkwy.	
14. FATHER'S NAME FIRST MIDDLE LAST Leo Paul Van Rie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Orsholski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII	17. INFORMANT ADDRESS Dennis Liddy Churchton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alveolar cell carcinoma of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Premature atrial contractions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>2-30</u> 19 <u>81</u> , to <u>8-15</u> 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>8-14</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>GAMITCHEL MD</u>		DEGREE		22c. DATE SIGNED <u>8-17-81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G Mitchell MD</u>		22e. ADDRESS <u>1616 Forest Dr. Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/18/81	23c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows		23d. LOCATION CITY OR TOWN COUNTY STATE West River, Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 17 1981	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF AGRICULTURE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE N. LAST LOTITO					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28, 1981				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 16 1895		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		2b. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10 CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home - 8491 Laurel Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8491 Laurel Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Luke Nanna					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Borregine				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215 05 4262		17 INFORMANT ADDRESS Rose Sebald same as 13 e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles J. Wu</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/31/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU			22e. ADDRESS 7845 Oakwood Rd. Glen Burnie Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/1/81		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24 FUNERAL DIRECTOR NAME George J. Gonce			ADDRESS 4001 Ritchie Hwy			25a. DATE REC'D. BY REGISTRAR SEP 2 1981		25b. REGISTRAR'S SIGNATURE Charles J. Wu	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN WILLIS MARTIN JR</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>31</b> YEAR <b>1981</b>			2b. HOUR <b>5:30</b> AM					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>4</b> YEAR <b>1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.					
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MELVIN RD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSURANCE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>AA</b> 13c. CITY OR TOWN <b>ANNAPOLIS</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>MELVIN RD</b>		
14. FATHER'S NAME FIRST <b>J. WILLIS</b> MIDDLE <b>MARTIN</b> LAST <b>SR</b>						15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b>MARTIN</b> LAST <b>#13</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT <b>NINA MARTIN</b>			ADDRESS <b>#13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Car Injury</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19____, to <b>8/31/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>8/28/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Stanley Watkins</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/31/81</b>		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STANLEY WATKINS</b>						22e. ADDRESS <b>121 CATHEDRAL ST. ANNAP. MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9-2-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anne's Cem.</b>			23d. LOCATION CITY OR TOWN <b>ANNAPOLIS</b> COUNTY <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>JOHN M. TAYLOR</b> ADDRESS <b>SEAS ANNAPOLIS MD</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1981</b>			25b. REGISTRAR'S SIGNATURE <b>Anne [Signature]</b>		

The medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8119852	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Olivia Martin</b>						2a DATE OF DEATH MONTH DAY YEAR <b>August 10, 1981</b>		2b HOUR <b>6:45a M</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 22, 1927</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>					
10 CITY OR TOWN OF DEATH <b>Crownsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crownsville Hospital Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2423 E. Oliver St.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Felix Vaughn (deceased)</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Rembret (deceased)</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>220-66-5976</b>		17 INFORMANT ADDRESS <b>BEATRICE BROWN 1531 N. MILTON AVE.</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Box</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1) <b>Bronchial asthma</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (we) lost above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Diwan S. Bhathal M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>8-10-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIWAN S. BHATHAL</b>				22e. ADDRESS <b>Crownsville Hosp. Center, Md 21032</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW CEM</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE, MD.</b>			
24 FUNERAL DIRECTOR NAME <b>WM. C. MARCH F/H 1101 E. NORTH AVENUE</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1981</b>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>					



August 19, 1951

W. H. R. H. H.

July 19, 1951

W. H. R. H. H.

W. H. R. H. H.

W. H. R. H. H.

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W. H. R. H. H.

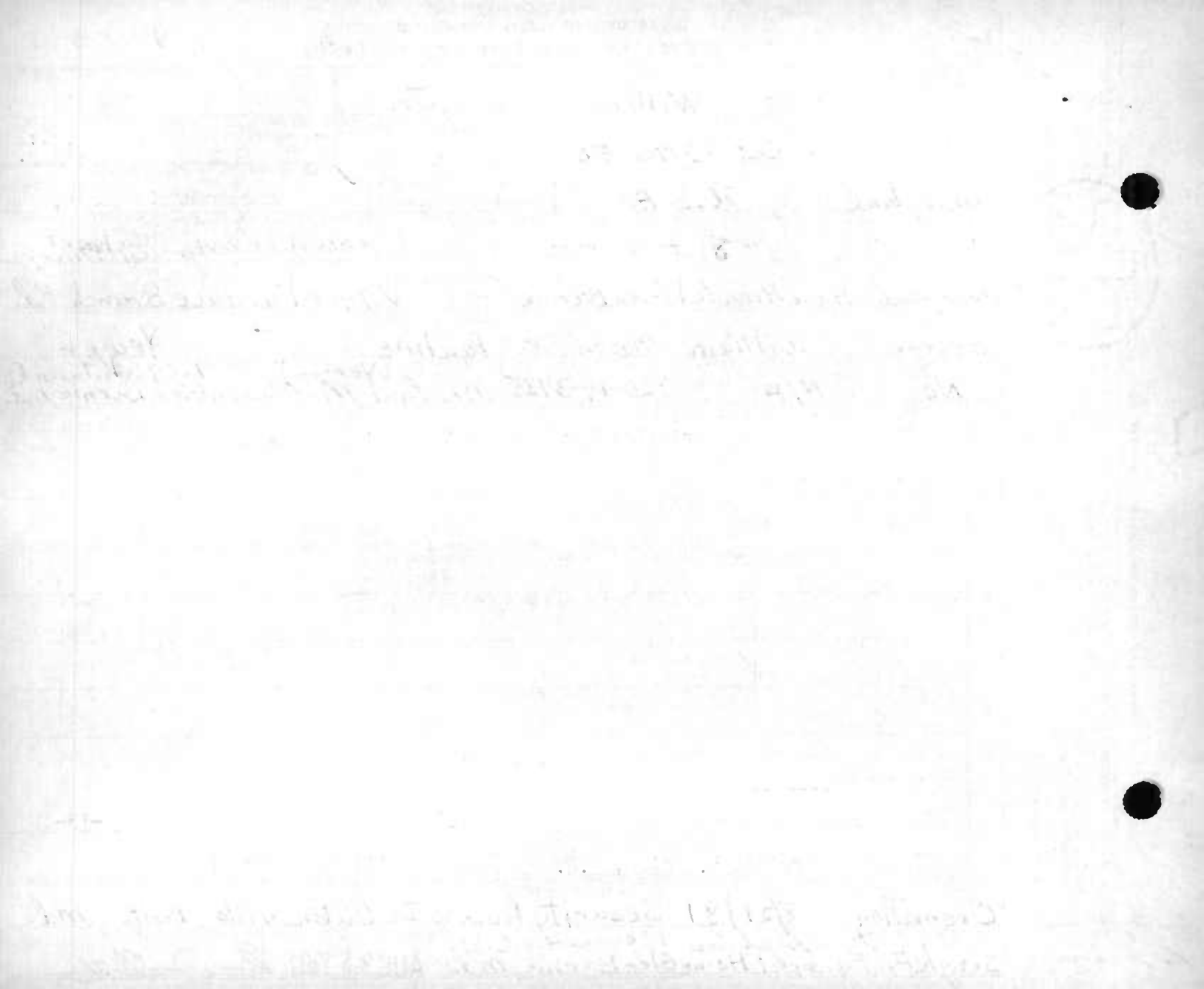
W. H. R. H. H.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VRA 15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19853	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) George William Mason, Jr.						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8 8 19 81		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23 1924 56 YRS.		6. AGE (IN YEARS) (LAST BIRTHDAY) 56 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 12 19 81		2d. HOUR 5:25 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7428 Furnace Branch Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wake House Worker		12b. KIND OF BUSINESS OR INDUSTRY Salvage Distillery			
13a. STATE Maryland						13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME George William Mason, Sr.						15. MOTHER'S MAIDEN NAME Pauline Yeager		16. SOCIAL SECURITY NO. 220-14-3985			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Nephew) Mr. Paul M. Mason			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan						TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 8-13-81	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 8/21/81		23c. NAME OF CEMETERY OR CREMATORY Security Process Inc		23d. LOCATION CITY OR TOWN COUNTY STATE Catonville Balt. md.			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home						1 Second Ave. S.W. Glen Burnie, md.		25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE Thomas J. North	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

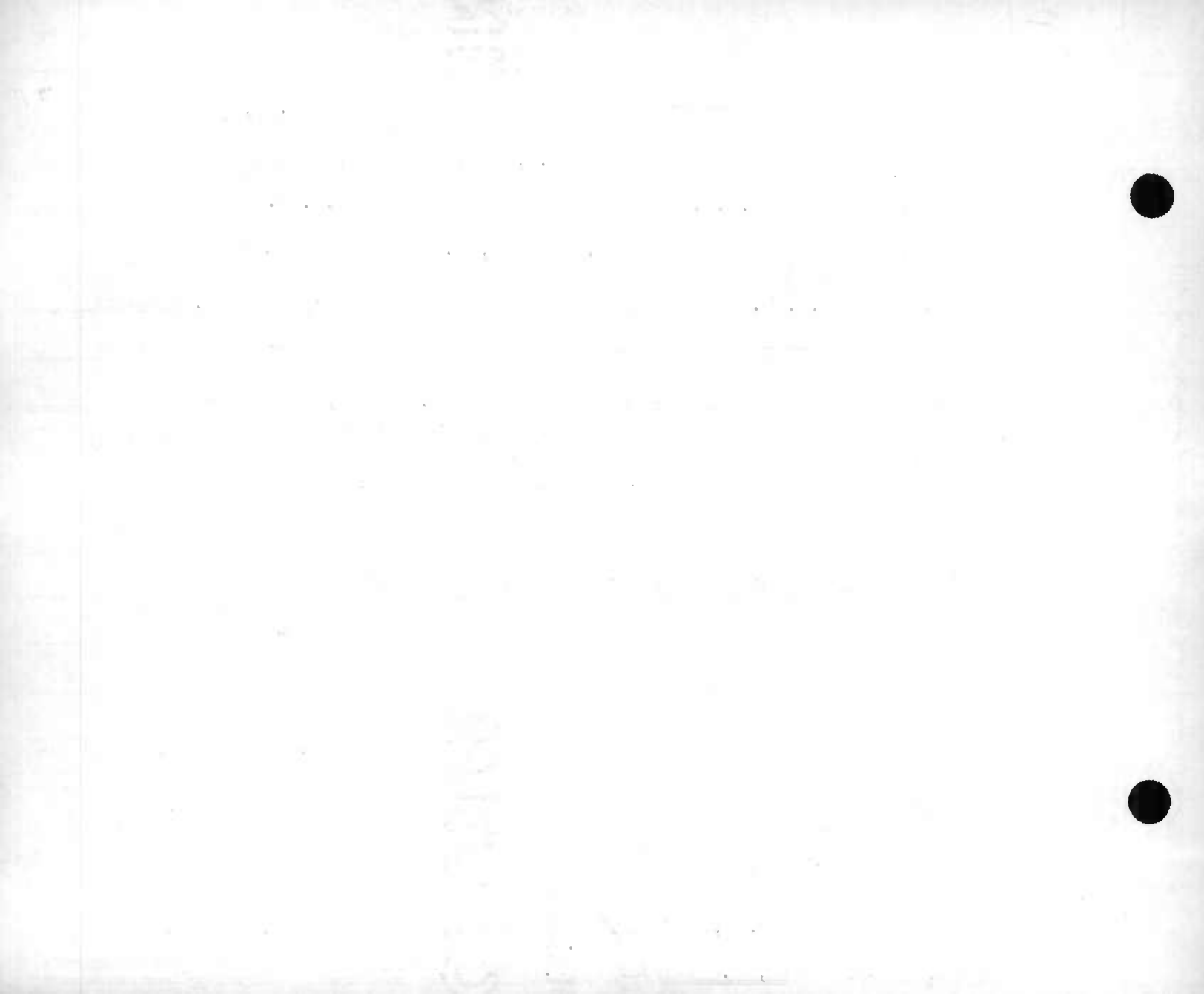
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 8 5 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Loretta		-----		Maxwell				Aug. 5,		1981		10:30	P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Female		White		Sept. 2, 1891		89		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.A.				A.A.Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Pasadena		7713 Knotley Rd. Pasadena, Md.		Housewife									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		A.A.Co.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7713 Knotley Rd. Pasadena					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Arthur		Layton		Emma		Ritter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		220-24-6139		Richard R. Maxwell,		Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST										5 MIN			
4354 DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION										1 HR			
DUE TO, OR AS A CONSEQUENCE OF (c) CARDIO MYOPATHY										2 YRS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
RENAL FAILURE, CARDIAC ARRHYTHMIAS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 6, 1981, to AUGUST 5, 1981, that (II) (we) last saw the deceased alive on JUNE 20, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED							
Steven T. Kariya		MD				8-6-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
STEVEN T. KARIYA, MD		JOHNS HOPKINS HOSP, BALTIMORE MD 21205											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Aug. 10, 1981		Cedar Hill Cemetery		Baltimore		Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
McGully Funeral Home, Mt. & Tickle Rd. Pasadena, Md. 21122				AUG 7 1981		James J. [Signature]							

BP \_\_\_\_\_

DHMM-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 1 19855 CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST Anna Mazur					MONTH DAY YEAR 8-12-81					
3. SEX FEMALE		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 2 17 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82		7b. HOUR 8:30 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL		MD.		
10. CITY OR TOWN OF DEATH Clematis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.		13b. COUNTY Anne Arun		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1225 Lake Pl.		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Wengrzym					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   IF YES, GIVE WAR OR DATES No					16b. SOCIAL SECURITY NO. 288-19-1159		17. INFORMANT ADDRESS Emmanuel Smiechowski Place 1225 Lake			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF 4280 DUE TO, OR AS A CONSEQUENCE OF (b) Ex. ④ tibia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from July 6, 1981, to 8/12, 1981, that (I) (we) lost saw the deceased at the above, (I) (we) did not view the body after death, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated										
22b. SIGNATURE Gregory Mitchell					DEGREE TENDING PHYSICIAN		MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/13/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory Mitchell					22e. ADDRESS 1616 Forest Dr. Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/17/81		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son 2818 E. Baltimore St.					25. DATE RECEIVED BY REGISTRAR AUG 17 1981					

MEDICAL CERTIFICATION



2 12 1899 28

X

1222 Lake St.

MB. James A. Brown

Wentworth

Wentworth

1222 Lake St.

MB.

1222 Lake St. Baltimore

1222 Lake St. Baltimore



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1- FOR STATE REGISTRAR		Items Part 2a: 19a., 21a.-21f. STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 1985 6	
Film#G558 8-31-81 AL		Info. added Film G559 9/2/81 rc		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dorothy Broas McDowell</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8-9-81</b>		2b. HOUR <b>2:15 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 12, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD	
10. CITY OR TOWN OF DEATH <b>ANNE ARUNDEL</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>General Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>West Grove</b>		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>1616 Farnborn St. R.D. #1, Box 263 Crofton Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Henry Broas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Hattie Carpenter Willson Pickett</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO			
16b. SOCIAL SECURITY NO. <b>199-32-6770</b>		17. INFORMANT ADDRESS <b>Dorothy McDowell Morris 1616 Farnborn St. Norman McDowell, Box 263, W. Grove, Panna, Md. 21114</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <b>8880 IMMEDIATE CAUSE (a) Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Quadruplegia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fractured Displacement C5+C6</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pa. fell out of bed-senile-dementia&amp;Confusion</b>							
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 26 81 P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Pt. fell out of bed.</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1616 Fair lain St. 21114 Crofton, Md.</b>			
22a. I certify that (1) this hospital attended the deceased from <b>8/1/81</b> to <b>8/9/81</b> , that (we) lost saw the deceased alive on <b>8/9/81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) we did not view the body after death. <b>Accident</b>							
22b. SIGNATURE <b>N.P. Kiteinos M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 11, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N.P. KITEINOS</b>		22e. ADDRESS <b>121 Cathedral St., Annapolis, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 12, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New London Presby. Cem</b>		23d. LOCATION <b>New London, Panna.</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>		ADDRESS <b>1212 West St., Annapolis, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 14 1981</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19857			
1. DECEASED NAME (TYPE OR PRINT) <b>FRANCES P. MC KITTRICK</b>										2a. DATE OF DEATH <b>8/8/81</b> 19		2b. HOUR <b>12:24</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>Feb. 14 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>8/8/81</b> 19		2d. HOUR <b>12:24</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD	
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS, MD.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL GEN'L HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>BALTO. CITY</b>		13c. CITY OR TOWN <b>BALTO. CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1002 E. 36th St., Balto., Md.</b>			
14. FATHER'S NAME <b>August Pfeifer</b>				15. MOTHER'S MAIDEN NAME <b>Anna Bartolomeo</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-16-2678</b>				17. INFORMANT <b>John G. McKittrick</b>				ADDRESS <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4149 Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>E. Linhardt</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>8-8-81</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>				ADDRESS <b>Annapolis, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-11-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, MD</b>					
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>5305 Harford Rd. 21214</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Hester</b>					

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 1 9 8 5 8

1 DECEASED NAME (TYPE OR PRINT) <b>Frank T. McMahon</b>			2a DATE OF DEATH MONTH <b>08</b> DAY <b>26</b> YEAR <b>81</b>			2b HOUR <b>12:30 A</b>					
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>10</b> DAY <b>10</b> YEAR <b>02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS			7 IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unknown</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.					
10 CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Plaza Manor Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b KIND OF BUSINESS OR INDUSTRY -----		
13a STATE <b>Md.</b>			13b COUNTY <b>A.A. Co.</b>		13c CITY OR TOWN -----		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>7355 Furnace Branch Rd.</b>		
14 FATHER'S NAME FIRST <b>Dennis</b> MIDDLE <b>Mc</b> LAST <b>Mahon</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Frances</b> MIDDLE <b>Dalton</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. <b>521-16-4413</b>			17 INFORMANT ADDRESS <b>Joanne Titiles 7355 Furnace Br. Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardiovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 yr.</b> <b>15 yrs.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Deactive STS</b>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> , 19 <b>81</b> , to <b>8/26</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>8/26</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edward O. Hunt Jr.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/26/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward O. Hunt Jr.</b>						22e. ADDRESS <b>7355 Furnace Branch Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/28/81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hwy. Balto., Md 21225</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1981</b>			25b. REGISTRAR'S SIGNATURE <b>Thomas J. Nathan</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a signature or initials, in the center of the page.





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 5 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SARAH</b>		FIRST <b>Middle</b>		LAST <b>eton</b>		2a. DATE OF DEATH MONTH <b>8</b> DAY <b>3</b> YEAR <b>81</b>			2b. HOUR <b>1 AM</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>15</b> YEAR <b>09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>UNKNOWN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b>					
10. CITY OR TOWN OF DEATH <b>AA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CROWNSVILLE Hosp CTR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNKNOWN</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>						13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>CROWNSVILLE Hosp Ctr.</b>			RECORD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4292**  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASCD**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**OBS - Hiatal Hernia**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>Aug 3</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Diwan S. Bhathal or. O.</b>				DEGREE		22c. DATE SIGNED <b>8-3-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIWAN S. BHATHAL</b>				22e. ADDRESS <b>Crownsville Hospital Center, Ind. 21032</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>8-7-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CREMATORY</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY STATE	
24. FUNERAL DIRECTOR <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Marie Jean Thibault</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 6 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
MILLER ELIZABETH MILLER		8 27 81		A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
FEMALE	WHITE	3 27 05	76 YRS.	ANNE ARUNDEL MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
GERMANY	USA		ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CROWNSVILLE, MD.	FAIRFIELD NURSING CENTER	HOUSEWIFE	HOME		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD.	AA	ANNAPOLIS	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1912 DULANEY PLACE	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
FRIEDRICH HIRSCHFELD	EMMA HARTMANN	NO (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
16a. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
214050555D	MRS. ALFRIEDA ATWELL ANNAPOLIS MD.	PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) none APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 9 years.			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
none					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/10 19 72, to 8/27 19 81, that (I) (we) lost saw the deceased alive on 8/12 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. M. McLaughlin, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/27/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
		3708 Mountain Rd. Pasadena, Md.			
23a. BURIAL, CREMATION, REMOVAL (CITY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION OR TOWN COUNTY STATE		
BURIAL	8-29-81	CEDAR BLUFF Cem.	ANNAPOLIS AA MD.		
24. FUNERAL DIRECTOR NAME		25. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John M. Lapher & Sons		AUG 31 1981			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8119861		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) JENNY CECILIA MILLER				2a. DATE OF DEATH AUGUST 10, 81		2b. HOUR 7 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Feb. 15, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10 CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Md. Manor Nsg. Home		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a STATE Maryland		13b COUNTY A.A.		13c CITY OR TOWN Severna Pk.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 372 Sheffield Road	
14 FATHER'S NAME Diedrkk				15. MOTHER'S MAIDEN NAME "Marie" Johance Elvebaka					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b (IF YES, GIVE WAR OR DATES) N/A		16c SOCIAL SECURITY NO 213.07.8785		17 INFORMANT (Grandson- In-Law) Same as # 13 Mr. Noel B. Benton			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22a SIGNATURE <i>Michael B. Pearlman</i>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/10/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Pearlman				22e ADDRESS Old Court Rd Reisterstown Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 13 Aug. 81		23c NAME OF CEMETERY OR CREMATORY Security Process Inc. Catonsville, Balto., MD.		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 17 1981		25b. REGISTRAR'S SIGNATURE <i>Rose Ann [Signature]</i>			

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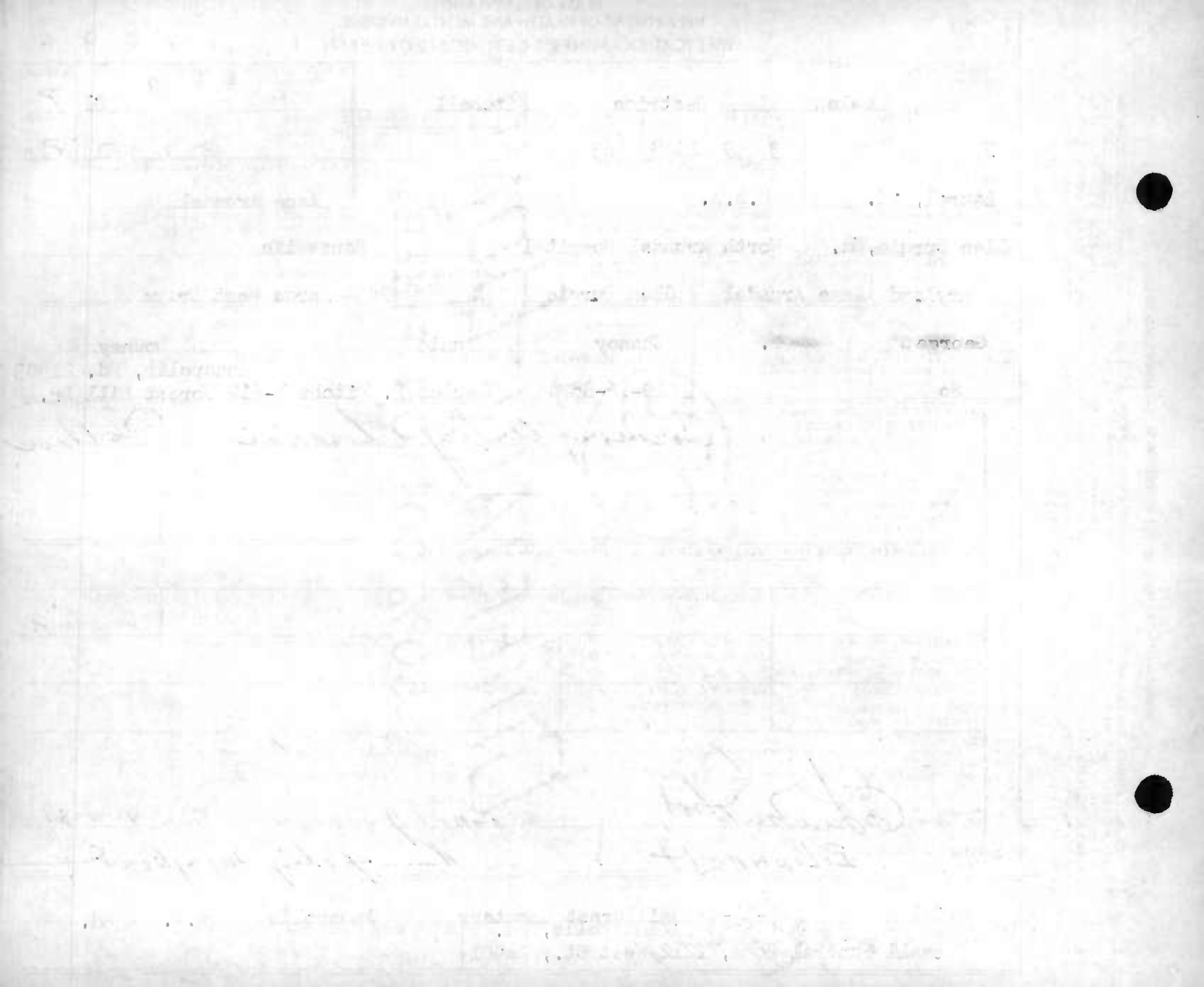
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (1))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19862	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Beatrice Mitchell							2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 9 1981		2b. HOUR 7 M		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 9 1918		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 9 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Laurel, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Glen Burnie, Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7834 Parke West Drive			
14. FATHER'S NAME FIRST MIDDLE LAST George Chaney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Downey				16. ADDRESS Annapolis, Md. 21403			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-8874		17. INFORMANT Charles P. Mitchell-612 Forest Hill Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Further	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE E. Linhardt				TITLE (SPECIFY) M.D. Dept 9 MEDICAL EXAMINER				DATE SIGNED 8-10-81			
EXAMINER'S NAME (TYPE OR PRINT) E. Linhardt				ADDRESS Annapolis, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-12-81		23c. NAME OF CEMETERY OR CREMATORY Willcrest Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Md.			
24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., 21401				25a. DATE REC'D. BY REGISTRAR AUG 14 1981		25b. REGISTRAR'S SIGNATURE					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) William J Mohler Sr.		2. DATE OF DEATH MONTH DAY YEAR August 18, 1981		7b. HOUR 3:30 PM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Oct 21 00		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		8. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10. CITY OR TOWN OF DEATH Churchton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5559 Gloucester St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Garage Foreman		12b. KIND OF BUSINESS OR INDUSTRY D C transit	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Churchton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Mohler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hentietta Heise		13e. STREET ADDRESS 1211 Cove Drive			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WM T 578 10 7808		17. INFORMANT ADDRESS Virginia St. Clair same as #11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Multiple myeloma 2030 DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c). DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Congestive Heart Failure							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-19-77 to Aug. 18, 1981, that (I) (we) lost saw the deceased alive on August 10, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas M. Walsh MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-19-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS M. WALSH		22e. ADDRESS 6146 Shady Side Rd. Shady Side Md					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/21/81		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg P.G. Md	
24. FUNERAL DIRECTOR NAME Rausch Funeral Home		ADDRESS Owings Md.		25. DATE RECEIVED BY REGISTRAR AUG 24 1981			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		E.D.T.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MINNIE GRACE MONEYPENNY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 27, 1981</b>				2b. HOUR <b>12:00PM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 24 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>							
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2 Sunset Circle 21122</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmer Griffith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva ?</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>232-01-6073</b>		17. INFORMANT ADDRESS <b>Wilma Buggenhagen, same as 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MI</b> 2390 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION <b>8/27/81</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intest. Surg. Stomach</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>425 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061</b>								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Paul M. Rosoff</b>						DEGREE		22c. DATE SIGNED <b>8/27/81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL M. ROSOFF, M.D.</b>						22e. ADDRESS <b>425 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/31/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat. Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Howard Md.</b>						
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCully F.H. Mountain &amp; Tick Neck Rds. 21122</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 1 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Dorcas Jean Weather</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 6 5  
REG. NO. E.D.T.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>COLEL (nmn) MOORE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 21, 1981</b>		2b. HOUR <b>1:54 P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 2, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Sgt.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Odenton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>1302 Damascus Street</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>William Moore</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(UNKNOWN)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II 243.10.6813</b>		17. INFORMANT (Companion) ADDRESS <b>Mrs. Edna B. Monson Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5789 IMMEDIATE CAUSE (a) Cardiorespiratory &amp; hypoxemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>U &amp; I bleed</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>None</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Marc Kaplan</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>22 AUG '81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC KAPLAN, M.D.</b>		22e. ADDRESS <b>7845 OAKWOOD ROAD #200 GLEN BURNIE, MARYLAND, 21061</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>26 AUG '81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winston Salem, Forsyth, N.C.</b>	
24. FUNERAL DIRECTOR NAME <i>G. Easter</i>		ADDRESS <b>Glen Burnie Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1981</b>		25b. REGISTRAR SIGNATURE <i>James J. Easter</i>	

BP

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 8 6 6 E.D.T.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VASHTI AGNES MOSBY										2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15, 1981		2b. HOUR 3:04 P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR APRIL 11, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Md.				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1756 Linkwood Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Lucious Knight				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Blakey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Wm. B. Mosby, Sr. (son)		ADDRESS Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Ira E. Kaplan, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/15/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA E. KAPLAN M.D.				22e. ADDRESS SUITE 200 OAKWOOD PROFESSIONAL BLDG. 7845 OAKWOOD ROAD, GLEN BURNIE MARYLAND CITY OR TOWN COUNTY STATE Lincoln-Lancaster- Neb.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/20/81		23c. NAME OF CEMETERY OR CREMATORY Wyuka Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lincoln-Lancaster- Neb.							
24. FUNERAL DIRECTOR NAME E. Barnes Fleming Funeral Service- Benson, Md.				25a. DATE REC'D. BY REGISTRAR AUG 18 1981		25b. REGISTRAR'S SIGNATURE James J. North							





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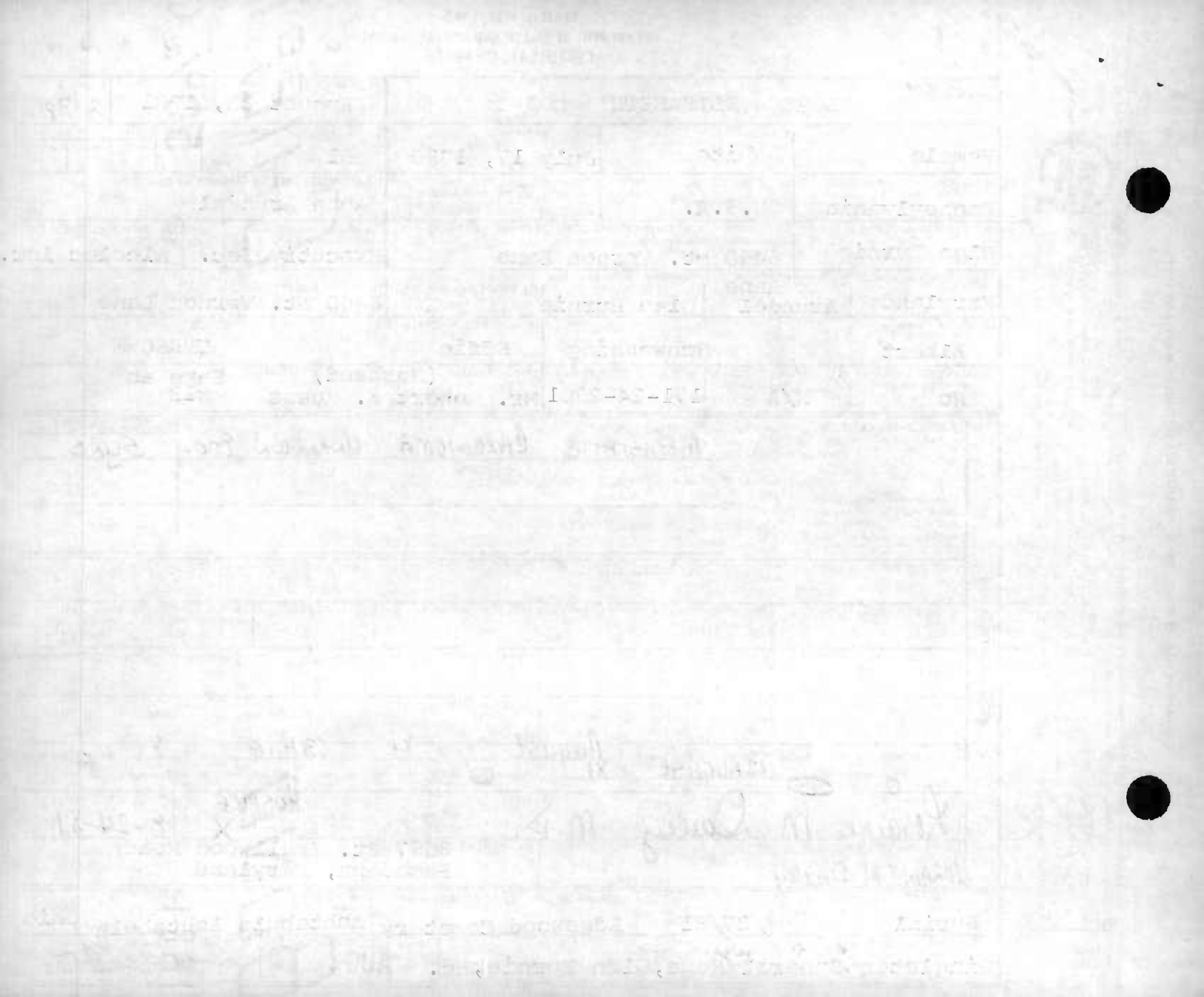
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8119867	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>DOLORES ELIZABETH MOSES</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>August 23, 1981</b>			2b. HOUR <b>3:15 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 17, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6460 Mt. Vernon Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Executive Sec.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Alcolac Inc.</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6460 Mt. Vernon Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Schwenning</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Effie UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT (Husband) ADDRESS <b>Mr. Robert K. Moses Same as #13</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1991</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA UNKNOWN ETC.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 81</b> , 19 <b>81</b> , to <b>23 Aug</b> , 19 <b>81</b> , that (we) last saw the deceased alive on <b>12 August</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did (did not) view the body after death.											
22b. SIGNATURE <b>Lorraine M. Dailey</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-24-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LORRAINE M. DAILEY</b>				22e. ADDRESS <b>8667 Ft. Smallwood Road Pasadena, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Edgewood Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ashtabula Ashtabula Ohio</b>		
24. FUNERAL DIRECTOR NAME <b>R. H. Hopkins</b>				ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Charles L. Narer</b>									
1. DECEASED NAME (TYPE OR PRINT) <b>Charles L. NARER</b>						2a. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>81</b>		2b. HOUR <b>8:30 AM</b>	
3 SEX <b>male</b>		4 RACE <b>cauc</b>		5 DATE OF BIRTH MONTH <b>07</b> DAY <b>01</b> YEAR <b>04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>W.T. Cowan</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Md.</b>		13b COUNTY <b>A.A.</b>		13c CITY OR TOWN <b>Glen Burnie</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>450 Fontana Ct.</b>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b></b> LAST <b>Narer</b>					15 MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b></b> LAST <b>Snoops</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>212 05 8764</b>		17 INFORMANT ADDRESS <b>Elizabeth Narer same as 13 e</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1509</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b></b>									
19a DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>					
21d. INJURY OCCURRED <b></b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>					
22a I certify that (I) (this hospital) attended the deceased from <b>8/10</b> 19 <b>81</b> , to <b>8/11</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>8/10</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Arthur H. Schwartz MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>8/11/81</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur H. Schwartz MD</b>		22e ADDRESS <b>121 Cathedral Ave Md</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>Baltimore Md. 21225 4001 Ritchie Hgwy</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1981</b> 25b. REGISTRAR'S SIGNATURE <b>James J. Heston</b>			

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James H. Carter

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George H. Bush

John F. Kennedy

Richard M. Nixon

Bill Clinton

Barack Obama

Mit Romney

Paul Ryan

Marco Rubio

Chris Christie

Scott Walker

Greg Abbott

Phil Murphy

John Hickenlooper

Steve Beshear

Mark E. Fisher

George A. Long

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BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 6 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Stehman NEAL</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>28</b> YEAR <b>81</b>			2b. HOUR <b>11</b> MIN <b>50</b> AM			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>10</b> YEAR <b>90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS <b>91</b> DAYS <b>91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cume Grande</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cumagons</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET ADDRESS) <b>General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Newspaper Writer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Service</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>A. A. Annapolis</b>		13c. CITY OR TOWN <b>736 J. Fairview Ave</b>		13d. STREET ADDRESS <b>736 J. Fairview Ave</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>E.</b> LAST <b>Neal</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lidia</b> MIDDLE <b>UNK</b> LAST <b>UNK</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR YEARS) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>085-05-6453</b>		17. INFORMANT <b>Willie Margaret Neat</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACVD - Pulmonary Edema</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10+d.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Duodenal ulcer &amp; bleeding</b>									
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) _____					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-6-1980</b> to <b>8-28-1981</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8-29-81</b> 19____, and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frank M. Shipley</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-28-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.M. SHIPLEY, M.D.</b>		22e. ADDRESS <b>Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8/29/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F. Lincoln Cemetery</b>		23d. LOCATION <b>Bethesda, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons</b>		ADDRESS <b>Annapolis, MD.</b>							

MEDICAL CERTIFICATION

01 16



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Morris NMN Peters</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>August 26 1981</b>		2b. HOUR PM <b>2:30 PM</b>	
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 10 1917</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>A.A. Co</b> MD.					
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>711 Bestgate Road</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gardens Supt</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Naval</b>			
13a STATE <b>Md</b>				13b COUNTY <b>A.A. Co</b>		13c CITY OR TOWN <b>Annapolis</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>711 Bestgate Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Morris Peters</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Foster</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW11</b>				16b SOCIAL SECURITY NO. <b>212 16 6639</b>		17. INFORMANT ADDRESS <b>Margaret Peters 711 Bestgate Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure - Uremic Syndrome</b> 1850 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral Ureteral Obstruction</b> 3 mos (c) <b>Extensive Adenocarcinoma Prostate</b> 5 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>Sept 19 78</b> to <b>Aug 22, 19 81</b> , that (I) (we) lost saw the deceased alive on <b>Aug 22 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William C Maxted, M.D.</b>				DEGREE				22c. DATE SIGNED <b>Aug 28, 1981</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C Maxted</b>				22e. ADDRESS <b>Georgetown Univ Hosp Wash. DC</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-31-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fowlers</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>A.A. Co Md</b>					
24 FUNERAL DIRECTOR NAME <b>C.E. Hicks</b>				ADDRESS <b>111 1922 Forest drive</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

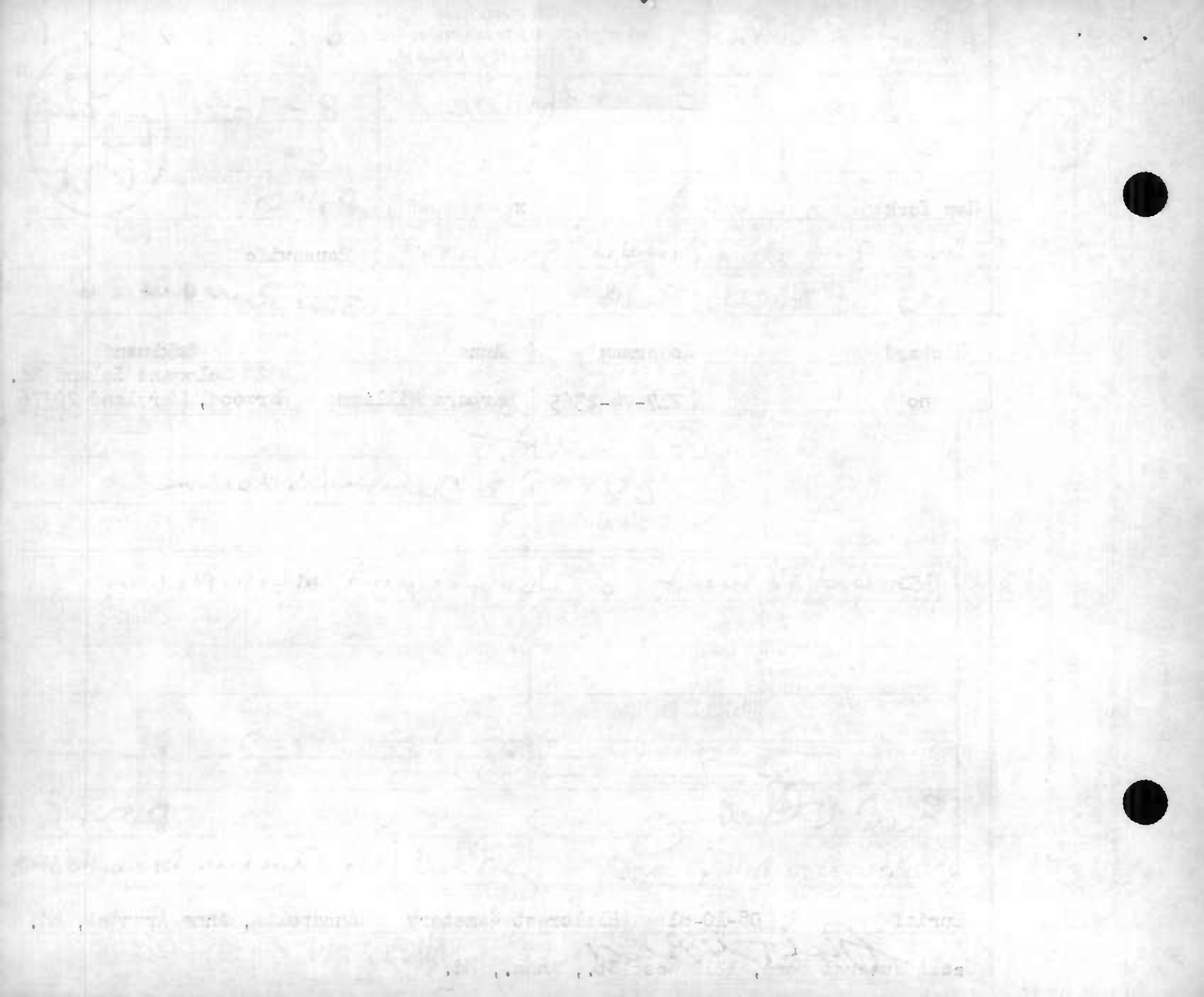
BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8119871	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vere E Phillips					2a. DATE OF DEATH MONTH DAY YEAR 8-7-81			2b. HOUR 8:20A.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8-21-11		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BACO MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Jail, Bosc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD BACO					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3058 River View Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST Richard Soderman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Eckluand						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-74-2365		17. INFORMANT Barbara Williams		43205 Solomons Island Rd. Harwood, Maryland 20776					
18. CAUSE OF DEATH (Enter only one cause per factor (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u> 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCAVD &amp; Occlusion &amp; Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cancer of R breast &amp; Insulin dependent Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-7-81</u> , 19 <u>81</u> , to <u>8-7-81</u> , 19 <u>81</u> , that (I) (we) lost <u>8-7-81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. A. Phillips MD				DEGREE		22c. DATE SIGNED 8-7-81.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. A. Phillips MD				22e. ADDRESS 20 Ridgeley Avenue Anne. Md 21401.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-10-81		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Anne Arundel, Md.					
24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Anna., Md.				25. DATE RECD. BY REGISTRAR AUG 12 1981		25b. REGISTRAR'S SIGNATURE					

Beall Funeral Home, 1212 West St., Anna., Md.

AUG 12 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8119872																			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR 8 27 81						2b. HOUR 1030 A M																	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby A. Placide						3 SEX Female						4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 30 02		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (COUNTRY) MARYLAND						7b. CITIZEN OF WHAT COUNTRY? USA						8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9 BALTIMORE CITY OR COUNTY OF DEATH CUNNE CRUNDAL CO MD.											
10 CITY OR TOWN OF DEATH Annapolis						11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE CRUNDAL General Hosp						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE						12b. KIND OF BUSINESS OR INDUSTRY HOME											
13a. STATE MARYLAND						13b. COUNTY ANNE ARUNDEL						13c. CITY OR TOWN SEVERNA PARK						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS 8 RIVER DR.					
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH A. WHEELER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IVA BAST						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 215-50-8989						17 INFORMANT ADDRESS DUDLEY PLACIDE (SAME AS 13)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure + C.H.F.																													
4049																													
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease																													
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1972, to 8-27 1981, that (I) (we) last saw the deceased alive on 8-26 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Donald Hislop MD DEGREE																		22c. DATE SIGNED 8/27/81											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Hislop																		22e. ADDRESS Robinson Rd. Severna Park MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE 8-31-81						23c. NAME OF CEMETERY OR CREMATORY WOODFIELD CEMETERY						23d. LOCATION CITY OR TOWN COUNTY STATE GALESVILLE ANNE ARUNDEL MD.											
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO																		25a. DATE REC'D. BY REGISTRAR 501 RITCHIE HWY SEVERNA PARK, MD				25b. REGISTRAR'S SIGNATURE SEP 01 1981							

BP

MARY ANN - NSA  
Cummings (line removed) top housewife  
NORTON and PHILIP STUMM  
Joshi H. Wheeler Iva  
NO - 218-20-2447 D. P. (SHIRLEY IS)

BRUNN 8-31-81  
WILLIAM C. STACY (in house)  
SEP 0 1981  
SEP 0 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

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12

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1

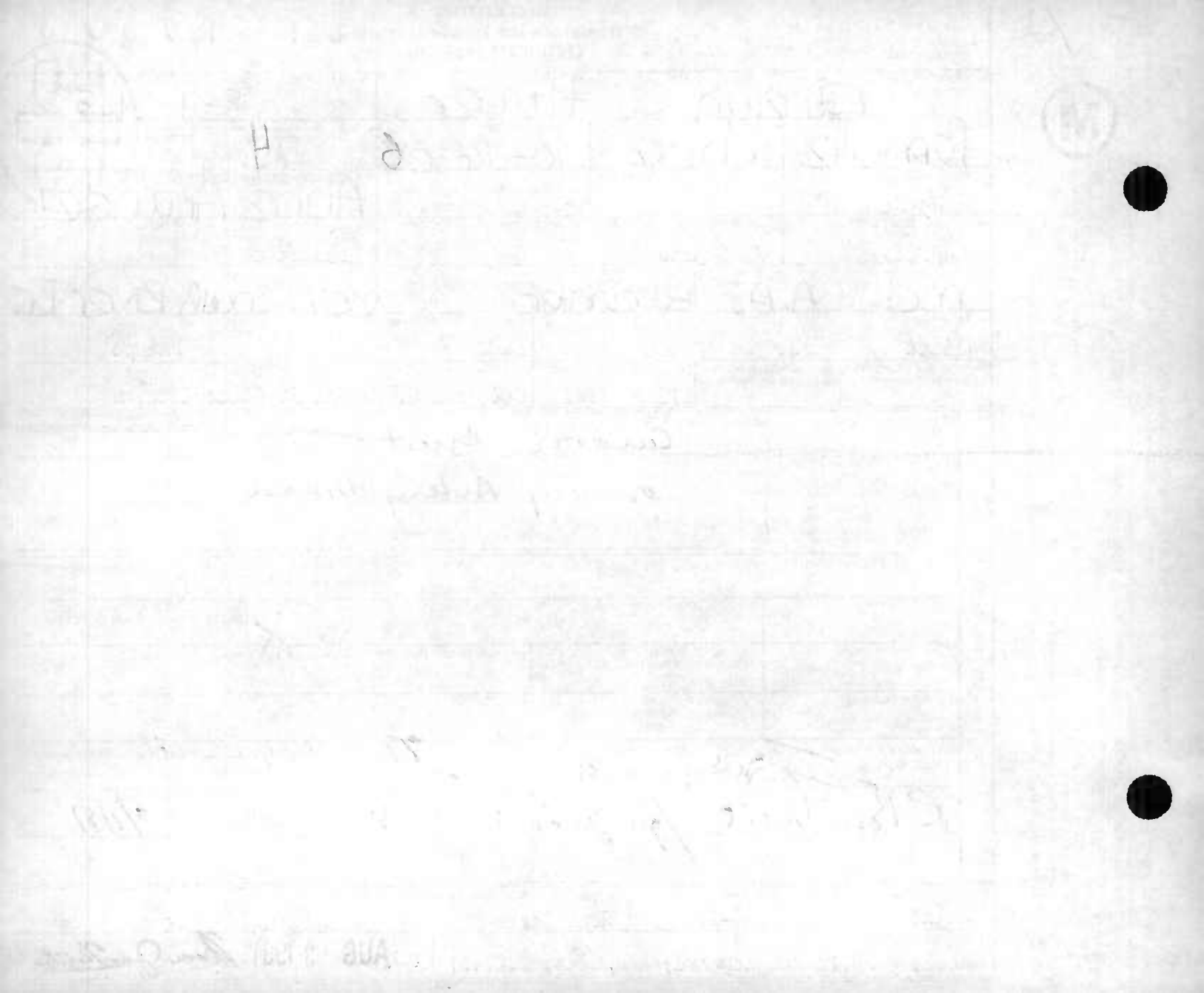
1 9 8 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ethelyn L. Purner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-1-81</b>			2b. HOUR <b>3:05 PM</b>		
3. SEX <b>female</b>			4. RACE <b>white</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>10-16-06</b>		
6. AGE (IN YEARS, MONTHS, DAYS) <b>74</b>			7. IF UNDER 1 YEAR MONTHS DAYS <b>YES</b>			7. IF UNDER 24 HRS. HOURS MIN. <b>YES</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Shady Side Md</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel MD.</b>			10. CITY OR TOWN OF DEATH <b>Annapolis</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AA General</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>md.</b>			13b. COUNTY <b>A.A.</b>			13c. CITY OR TOWN <b>Edgewater</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>3578 South River Trc</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert E. Lee</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lotta Phipps</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>212 52 3782</b>			17. INFORMANT ADDRESS <b>Clifford C. Purner Jr; Galesville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest -</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>coronary Artery Disease</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 79</b> to <b>Aug 1 81</b> , that (I) (we) last saw the deceased alive on <b>July 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) (not) view the body after death.								
22b. SIGNATURE <b>R. B. Hale</b>			22c. DEGREE <b>for Dr. Hale</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>8/1/81</b>
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-4-81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington DC</b>			24. FUNERAL DIRECTOR NAME ADDRESS <b>Hardesty FH, 12 Ridgely Ave; Annapolis, Md. 21401</b>					
25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>Thane J. Nathan</b>			25c. DATE <b>AUG 3 1981</b>		

BP





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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
		Clifford J. Queen Jr.						Aug. 23, 1981		840p M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. UNDER 1 YEAR		7. UNDER 24 HRS	
Male		White		10 30 54		26 YRS		MONTHS		DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Anne Arundel Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Arundel General Hospital				Electronics					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1125 Madison Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Clifford J. Queen, Sr.		Lillie Babbs		no		215-64-4938		Mrs. Donna Queen, Annapolis, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic renal failure</i> 5850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic obstructive pulmonary disease; Aortic atherosclerosis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18; PART 1; OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (the hospital) attended the deceased from Aug 19 81, to present, 19 81, that (1) (the hospital) saw the deceased alive on 8/19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (the hospital) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Eline Funeral Home, Md.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8/24/81.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		8-26-81		Hampstead Cemetery		Hampstead, Carroll Co., Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Eline Funeral Home, Hampstead, Md. 21074						AUG 26 1981		Thom J. [Signature]			

MEDICAL CERTIFICATION

2

Office of the Secretary of the Navy

Washington, D. C.  
June 10, 1961  
The Honorable Earl Warren  
U. S. Supreme Court Building  
Washington, D. C.

Dear Mr. Chief Justice:

I am writing to you regarding the case of *James Earl Ray*, who is currently in custody of the Federal Bureau of Investigation. I am sure that you are aware of the circumstances surrounding this case and the importance of a fair trial.

I am sure that you will take the necessary steps to ensure that the trial is conducted in a fair and impartial manner.

Sincerely,  
John Edgar Hoover  
Director, Federal Bureau of Investigation

AUG 2 1961

BP\_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19875			
1. DECEASED NAME (TYPE OR PRINT) Laura Lynn Rager						2a. DATE KNOWN OF DEATH ESTIMATED Aug. 27 19 81				7b. HOUR M P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 2 1963		6. AGE (IN YEARS) (LAST BIRTHDAY) 18 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 8 28 19 81			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD			
10. CITY OR TOWN OF DEATH Severn				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1905 Champlain Drive 21144				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N.S.A.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21144 7905 Stone Hearth Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST George Ellsworth Rager				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Virginia Lilley				16. ADDRESS 21144 7905 Stone Hearth Rd. Severn, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 231-86-7504				17. INFORMANT Jack O. Dodson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ligature strangulation and incised wound to neck 9630 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 27 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject was strangled and struck with glass							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1905 Champlain Dr., Severn, Anne Arundel Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE 8-29-81					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 31, 1981		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.		25. DATE REC'D. BY REGISTRAR SEP 1 1981			
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC 7601 Sandy Spring Rd. Laurel, Md. 20707												26. REGISTRAR'S SIGNATURE Thomas J. Hester	

1932

1932

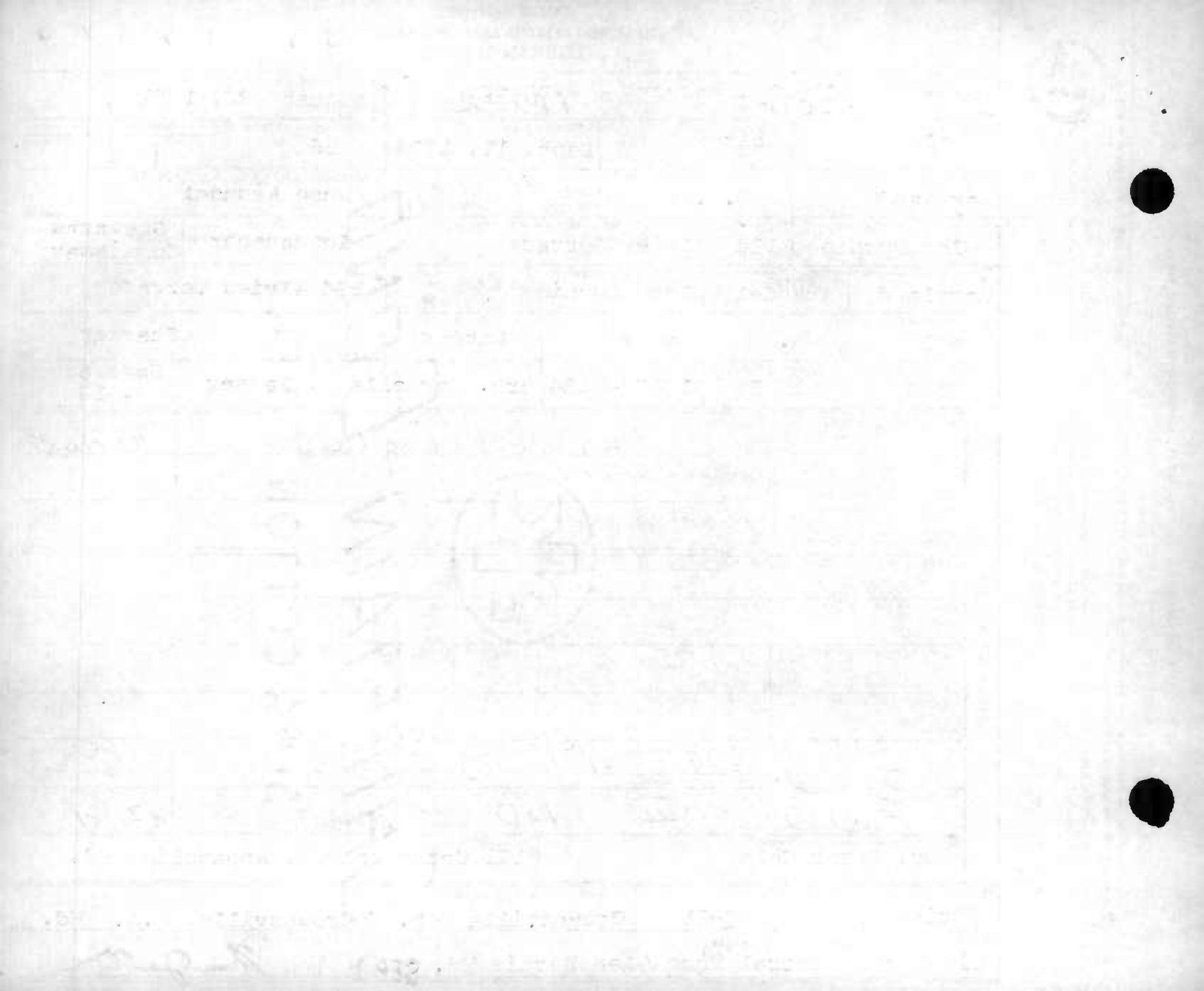
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8119876 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR M			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ALBERT Harvey RAUSER</b>				August 30, 1981			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) 124 Aiview Terrace		12a. USUAL OCCUPATION Salesmanager		12b. BUSINESS OR INDUSTRY Stewarts Commissary	
13a. STATE Maryland				13b. CITY OR TOWN Glen Burnie		13c. STREET ADDRESS 124 Aiview Terrace	
14. FATHER'S NAME FIRST MIDDLE LAST Paul M. Rauser				15. MOTHER'S MAIDEN NAME MIDDLE Catherine Starkey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 11 218-12-0134		17. INFORMANT (wife) ADDRESS Mrs. Carmella A. Rauser Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/2 8/1 to 8/31 1981, that (I) (we) lost saw the deceased alive on 8/24 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ensor Cole				DEGREE MD		22c. DATE SIGNED 8/31/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ensor Cole				22e. ADDRESS 121 Cathedral St. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-81		23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, A.A. Md.	
24. FUNERAL DIRECTOR NAME Dean P. Chittum				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 1 1981			
Singleton Funeral Home Glen Burnie Md.							





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 1 1 9 8 7 7  
D.S.T.1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (Formerly) JACK F. REED			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28, 1981		2b. HOUR 19:50P
3. SEX Male	4. RACE White	5. DATE OF BIRTH August 24, 1932	6. AGE (IN YEARS LAST BIRTHDAY) 49	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Orange, Co. Fla.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION Construction	12b. KIND OF BUSINESS OR INDUSTRY Union	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Anne Arundel	13c. CITY Glen Burnie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 15 Harvard Road	
14. FATHER'S NAME Harry A. Reed			15. MOTHER'S MAIDEN NAME Ruby B. Parker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (NO OR UNKNOWN) WW-II		16b. SOCIAL SECURITY NO. 267-36-9328	17. INFORMANT John F. Reed, Jr. 8000 Campus Ave. Jacksonville, Fla. 32208		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease. 5 yrs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased, from June 14, 1981, to August 26, 1981, that (I) (we) lost saw the deceased alive on August 26, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Reider		DEGREE M.D.		22c. DATE SIGNED 8/28/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER M.D.		22e. ADDRESS 1406 Crown Highway South Suite 107 Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 8/31/81	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION Baltimore, Maryland
24. FUNERAL DIRECTOR NAME E. Barnes Fleming Funeral Service			25a. DATE REC'D. BY REGISTRAR AUG 31 1981		

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(33)

2007 2008



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM HARPER REEM			2a. DATE OF DEATH MONTH DAY YEAR 8-12-81			2b. HOUR 80 M			
3. SEX male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 3 11 11		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - U.S. NAVY		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21 N. Cherrygrove Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Harper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1934-1957		17. INFORMANT ADDRESS Mrs. Dorothy Reem Sarcas #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intracerebral bleed</u> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> , 19 <u>87</u> , to <u>8/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.									
22b. SIGNATURE Jack Teitelbaum MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK TEITELBAUM MD			22e. ADDRESS 2981 Solomon Island, Edgewater Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-15-81		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Md		
24. FUNERAL DIRECTOR NAME <u>Beall Funeral Home</u> ADDRESS <u>1212 West St.</u> BALTIMORE, MD 21201									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EDT

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.		EDT			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>URSULA REESE</b>				3a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 20, 1981</b>		2b. HOUR <b>6:00 A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 29 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clifton H. Reese</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Kelly</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-40-4182</b>			
17. INFORMANT ADDRESS <b>Rev. J. Kelly Reese</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mult. pl. infarcts cardiac respiratory and</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>MI</b> (c) <b>MI</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Jaundice obstructive - liver failure - multiple myeloma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION <b>7/15/81</b>		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Jaundice obstructive - liver failure - multiple myeloma</b>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7/15/81</b>			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. SIGNATURE <b>Jorge B. Ramirez</b>		22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JORGE B. RAMIREZ, M.D.</b>		22c. ADDRESS <b>7845 Oakwood Road #205 Glen Burnie, Maryland 21061</b>		22d. DATE SIGNED <b>8/20/81</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/21/81</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		24b. ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Van Natta</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and present.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

EDT

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
LOUIS M W REINHARDT		AUGUST 7, 1981		7:30 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	March 16, 1928	53 YRS	IF UNDER 24 HRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Electrician's Helper		
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS		
Maryland		Baltimore	2906 Louisiana Avenue 21227		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Edward Reinhardt		Marie Zink			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
NO		214-24-6646	Balto. Md. 21227 Mrs. Mary E. Reinhardt 2906 Louisiana Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Respiratory Failure					2 day
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer					4 months
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
Urinary Tract Infection					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-19-81 to 8-7-81, that (I) (we) last saw the deceased alive on 8-7-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Long S. Hsu		M.D.		8-8-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
LONG S. HSU, M.D.		11085 LITTLE PATUXENT PARKWAY COLUMBIA, MARYLAND 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8/11/81	Loudon Park Cemetery	Baltimore Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mc Cully Funeral Home of Brooklyn 237 E. Patapsco Avenue Balto., Md. 21225		AUG 11 1981		Name [Signature]	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel Julia Reitz			2a. DATE OF DEATH MONTH DAY YEAR August 3, 81			2b. HOUR 6 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Md Manor Nsg Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Civil Serv.	
13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jesse C. Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Laragy			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A			
16b. SOCIAL SECURITY NO 212.20.8447			17. INFORMANT (Husband) ADDRESS Mr. John P. Reitz			17b. ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4360 CVA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael B. Pearlman						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/3/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Pearlman						22e. ADDRESS 5400 Old Court Rd Randallstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6 AUG. 81		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD.		
24. FUNERAL DIRECTOR NAME Singleton Funeral Home			ADDRESS Glen Burnie MD.			25a. DATE REC'D. BY REGISTRAR AUG 6 1981		25b. REGISTRAR'S SIGNATURE Name Jan [Signature]	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 8 2

REG. NO.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 1 1 9 8 8 2	
				REG. NO.					
<b>I. DECEASED NAME</b> (TYPE OR PRINT)				<b>2a. DATE OF DEATH</b>		<b>MONTH DAY YEAR</b>		<b>2b. HOUR</b>	
FIRST MIDDLE LAST <b>Charles D Ridout</b>				<b>8 27 81</b>		<b>A</b>			
<b>3. SEX</b>		<b>4. RACE</b>		<b>5. DATE OF BIRTH</b>		<b>6. AGE (IN YEARS LAST BIRTHDAY)</b>		<b>IF UNDER 1 YEAR</b>	
<b>Male</b>		<b>White</b>		MONTH DAY YEAR <b>12 21 1903</b>		<b>77</b>		YRS. MONTHS DAYS HOURS MIN.	
<b>7a. BIRTHPLACE</b> (STATE OR FOREIGN COUNTRY)		<b>7b. CITIZEN OF WHAT COUNTRY?</b>		<b>MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. BALTIMORE CITY OR COUNTY OF DEATH</b>			
<b>MD.</b>		<b>USA</b>				<b>HUNNE BRUNDEL MD</b>			
<b>10. CITY OR TOWN OF DEATH</b>		<b>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION</b> (IF NONE IN SUCH FACILITY GIVE STREET ADDRESS)				<b>12a. USUAL OCCUPATION</b> (TYPICAL WORK FOR MOST OF WORKING LIFE)		<b>12b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>S. MARGARETS</b>		<b>1049 WHITE HALL COVE RD</b>				<b>FORMER</b>		<b>FARM</b>	
<b>13a. STATE</b>		<b>13b. COUNTY</b>		<b>13c. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>13d. STREET ADDRESS</b>			
<b>MD.</b>		<b>AA S. Margarets</b>		<b>NO</b>		<b>1049</b>			
<b>14. FATHER'S NAME</b> FIRST MIDDLE LAST <b>Orlando Ridout</b>				<b>15. MOTHER'S MAIDEN NAME</b> FIRST MIDDLE LAST <b>MARIA Duvall</b>					
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		<b>16b. SOCIAL SECURITY NO.</b>		<b>17. ELIMINANT ADDRESS</b>		<b>Elinor P. Ridout # 13</b>			
<b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate with metastases</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs.</b>	
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</b>									
<b>19a. DATE OF OPERATION</b>		<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>				<b>20a. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. TIME OF INJURY</b> HOUR A.M. MONTH DAY YEAR P.M. 19		<b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
<b>21d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		<b>21f. LOCATION</b> STREET CITY OR TOWN COUNTY STATE					
<b>22a. I certify that (I) (this hospital) attended the deceased from</b> <b>8/21</b> <b>to</b> <b>8/27 1981</b> , <b>that (I) (we) lost</b> <b>saw the deceased alive on</b> <b>8/21</b> <b>and that in my (our) opinion death occurred on the date and hour and from the causes stated</b> <b>above, (I) (we) (did) (did not) view the body after death.</b>									
<b>22b. SIGNATURE</b>				<b>DEGREE</b>		<b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		<b>22c. DATE SIGNED</b> <b>8/27/81</b>	
<b>22d. PHYSICIAN'S NAME</b> (TYPE OR PRINT) <b>R. FEELER</b>				<b>22e. ADDRESS</b> <b>121 Cathedral St. Annapolis Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (SPECIFY)		<b>23b. DATE</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (CITY OR TOWN, COUNTY, STATE)			
<b>BURIAL</b>		<b>8/29/81</b>		<b>White Hall</b>		<b>S. Margarets Annapolis</b>			
<b>24. FUNERAL DIRECTOR</b> NAME ADDRESS		<b>25. REGISTRY CLERK</b> NAME ADDRESS							
<b>John M. L... Annapolis, Md.</b>		<b>AUC... Registry Clerk</b>							

4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

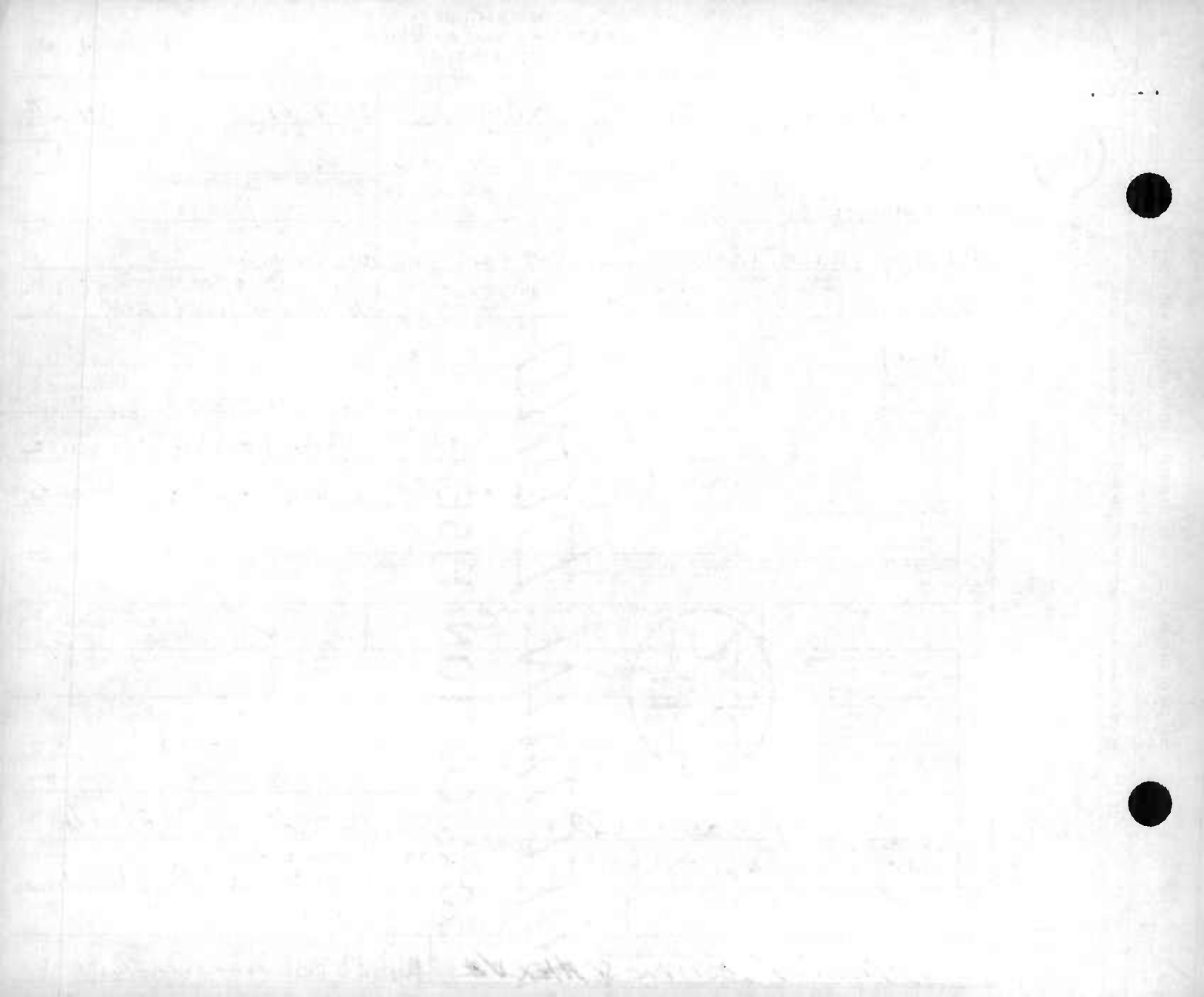
1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edward J. Riley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-22-81</b>		2b. HOUR <b>4:00 PM</b>		
3 SEX <b>MALE</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 29 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Hampshire</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL</b> MD.	
10. CITY OR TOWN OF DEATH <b>Crofton, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crofton Convalescent Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WESTERN-Union</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>XXXXXXXXXX</b>		13b. COUNTY <b>WASHINGTON, D.C.</b>		13c. STREET ADDRESS <b>7758 Church St., N.W.</b>		13d. CITY OR TOWN <b>WASHINGTON, D.C.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Riley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-09-8334</b>	
17. INFORMANT <b>NEPHEW</b>		18. ADDRESS <b>VIRGINIA</b>		19. NAME <b>JOHN H. CONLIN 6844 MURRAY LANE ANNANDALE</b>		20. CITY OR TOWN <b>VIRGINIA</b>	
21. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: <b>1539 Left ventricular failure</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		24. DATE SIGNED <b>8/22/81</b>	
25a. DATE OF OPERATION <b>8/20/81</b>		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary artery bypass graft</b>		26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:20 8/20 81</b>		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		27d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>	
27e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		27f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27g. DATE SIGNED <b>8/22/81</b>		27h. DATE SIGNED <b>8/22/81</b>	
27i. SIGNATURE <b>Max Frank MD</b>		27j. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAX FRANK MD</b>		27k. ADDRESS <b>7575 Ritchie Hwy MD 21061</b>		27l. DATE SIGNED <b>8/22/81</b>	
27m. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		27n. DATE <b>8/26/81</b>		27o. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>		27p. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D.C.</b>	
27q. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b>		27r. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MARYLAND</b>		27s. DATE REC'D. BY REGISTRAR <b>AUG 25 1981</b>		27t. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8119884 E.D.T. 4				
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS M. ROBINSON SR.				AUGUST 12, 1981				2:42 A.M.
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 75		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ottley Robinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 226-10-3165		17. INFORMANT ADDRESS Elberteen Robinson-Same as 13						
18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sudden myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Aug 11 19 81 to Aug 12 19 81, that (I) (we) lost saw the deceased alive on Aug 12 19 81, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.								
22b. SIGNATURE Charles J. Wu, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 204 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 15, 81		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR AUG 14 1981		25b. REGISTRAR'S SIGNATURE James S. Kirkley		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Nellie Monna Rodgers</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 25, 1981</b>			2b. HOUR <b>6 Pm</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 26 1926</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10 CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Admistrative Asst.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <b>md</b>		13b. COUNTY <b>A.A. Co</b>		13c. CITY OR TOWN <b>Chesctor</b>		13e. STREET ADDRESS <b>5455 Shady Side Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Landes</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ona Bland</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>236-40-7111</b>		17 INFORMANT <b>William Rodgers</b>			ADDRESS <b>13c</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Breast cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b> <b>5 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>8/29</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13/76</b> to <b>8/26/81</b> , that (I) (we) last saw the deceased alive on <b>8/29/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Aron Primack M.D.</b>						DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED <b>8/26/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Aron Primack M.D.</b>						22e. ADDRESS <b>106 Irving St. N.W. Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-27-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DAVIDSONVILLE ANN ARUNDEL</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>T. A. Hardesty Annapolis Md 21401</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1981</b>		25b. REGISTRAR SIGNATURE <b>James J. [Signature]</b>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 8 8 6	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Charles E. Russell</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>8-23-1981</b>			2b. HOUR <b>4:52 P</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 03 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired Manager - Hess Shoes</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>A. A.</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank J. Russell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louenia Lee</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>217-01-4152</b>		17. INFORMANT ADDRESS <b>Sue A. Russell - Sec. 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Acute Cardio-Respiratory Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>prob. coronary H.R. Disease</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8-25-81</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-11-1973</b> , 19____, to <b>8-23-1981</b> , 19____, that (I) (we) last saw the deceased alive on <b>5-28-81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Donald H. Hislop</b>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-25-1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald H. Hislop, M. D., P. A.</b>				22e. ADDRESS <b>Robinson Road Severna Park, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-26-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Robert S. Barranco</b>				ADDRESS <b>501 R. Lake Rd. Severna Park MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Anna J. [Signature]</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic element, the medical examiner must be notified at once.

DHM: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 8 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>William R Schneider Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 14 81</i>			2b. HOUR <i>12:25 AM</i>					
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>11 10 14</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>66 YRS.</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel MD.</i>					
10 CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General</i>				12a. USUAL OCCUPATION (TYPE AND NATURE OF WORKING LIFE) <i>Ret.</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>			13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>ANNAPOHIS</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3011 E. FRIENDS RD.</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>SCHWEIDER</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY GROVES</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>				16b. SOCIAL SECURITY NO. <i>220-09-6698</i>	
17 INFORMANT NAME <i>WM R. SCHWEIDER Jr.</i>			ADDRESS <i>761 MARINERS CIRCLE</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>					
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute antero-septal myocardial infarct</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Many years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Cardiac arrest</i>											
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1 August 19 81</i> to <i>14 August 19 81</i> , that (I) (we) last saw the deceased alive on <i>13 August 19 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles W. Kinzer</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>14 August 1981</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES W. KINZER M.D.</i>				22e. ADDRESS <i>ANNAPOLIS, MD. 21401</i>							
23a. BURIAL, CREMATION, REMOVAL <i>CREMATION</i>		23b. DATE <i>8/15/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>F. Lincoln</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood P.G. MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 19 1981</i>			
24. FUNERAL DIRECTOR NAME <i>John M. L...</i>		ADDRESS <i>...</i>		25b. REGISTRAR'S SIGNATURE <i>...</i>							

MEDICAL CERTIFICATION



*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Report may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 9 8 8 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Frances T. Schulz</b>				2a. DATE OF DEATH MONTH DAY YEAR 8-29-81 80 AM			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR 1-XXX-94		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>AA</b> MD.	
10 CITY OR TOWN OF DEATH <b>G.B.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MD. Manor</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Men's Tailoring</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Clothing-Max Rubin</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>		13b COUNTY <b>H.A.</b>		13c CITY OR TOWN <b>Brooklyn</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ferdinand Miller</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Ritten</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b SOCIAL SECURITY NO <b>213-03-6732A</b>		17 INFORMANT <b>Mrs. Frances E. Cooke</b>		ADDRESS <b>Baltimore, Md. 21225</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Scabrous Ulcers</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD &amp; Compensated Congestive Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>Years</b> <b>Years</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I (this hospital) attended the deceased from <b>Aug 28</b> , 19 <b>79</b> , to <b>Aug 29</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>Aug 29</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Peter H. Rheinstein, MD</b>				DEGREE <b>MD</b>		22c DATE SIGNED <b>Aug 30, 1981</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER H. RHEINSTEIN, MD</b>				22e ADDRESS <b>MARYLAND MANOR NURSING HOME</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>9/1/81</b>		23c NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Anne Arundel</b> STATE <b>Md.</b>	
24 FUNERAL DIRECTOR <b>Mc Cutty Funerai Home of Brooklyn</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 1 1981</b>		25b REGISTRAR'S SIGNATURE <b>James Van Natten</b>	
23f FUNERAL HOME ADDRESS <b>237 East Patapsco Avenue Baltimore, Md. 21225</b>							

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Letter

27-19-1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 9 8 8 9				
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Norman B. Schultz</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>8-7-81</b>		2b. HOUR <b>10:47</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-01-13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL Co MD.</b>			
10. CITY OR TOWN OF DEATH <b>ANNAPOLIS</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ANNE ARUNDEL General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>5502 Shady Side Rd Barber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>H.A.</b>		13c. CITY OR TOWN <b>Churchton</b>		13e. STREET ADDRESS <b>5502 Shady Side Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Schultz</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Buccholz</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>395-07-9998</b>		17. INFORMANT ADDRESS <b>Mrs. Lydia K. Schultz Churchton</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LUNG CANCER</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>CHRONIC LUNG DISEASE</b>									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>8/7</b> 19 <b>81</b> , to <b>8/7</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>8/7</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Donald C. Roane</b> M.D. DEGREE <b>M.D.</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/7/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald C. Roane M.D.</b>					22e. ADDRESS <b>134 OAKMOUNT ROAD 20728</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>8/7/81</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 14 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Smith</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										19890		
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR				
James EDWARDS SEARS SR.					Aug 26 81			330P				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		
MALE		White		MONTH DAY YEAR 03 04 04		77 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		USA.				HUNNE ARUNDEL MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
ANNAPOLIS		HAGEN Hosp.				CLERK		HARDWARE STORE				
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
MD.					H.A.		ANNAPOLIS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		901 BEST GATE RD	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
THOMAS SEARS					IDA V. KING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO					220 079262		MARY HILDA SEARS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of lung c</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1609 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastases to liver</u>										6 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										3 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cachexia; dehydration; pneumonia</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR P.M. 19								
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>May 81</u> to <u>Present</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/26</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.												
22a. SIGNATURE				DEGREE				22c. DATE SIGNED				
Peter F. VerKouw				ATTENDING PHYSICIAN				MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8/26/81		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS								
PETER F. VERKOW				1419 BEST DRIVE, ANNAPOLIS, MD.								
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
BURIAL				8-30-81		HILLCREST Cem.		ANNAPOLIS AA. MD.				
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
GAIL M. TAYLOR-SOUS ANNAPOLIS MD.				AUG 31 1981								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 901-200-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET MARIE SHERRY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>August 5, 1981</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 22 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>Md.</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>301 Dorchester Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles T. Roberts</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Lorek</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214 50 9429</b>		17. INFORMANT <b>Henry E. Sherry</b>		ADDRESS <b>Riviera Bch, Md. 161 Carroll Rd.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Deg. Arteriosclerosis, old CVA, Hypothyroidism</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7-14-81</b> to <b>7-14-81</b> , that (I) (we) lost <b>7-14-81</b> above, (I) (we) did not view the body after death.										
22b. SIGNATURE <b>S. K. BHATIANI</b> MD					DEGREE <b>MD</b>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. K. BHATIANI</b>					22e. ADDRESS <b>4030 FALL STAFF RD. BALTO 21214</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Stanislaus Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>					ADDRESS <b>Baltimore Md. 21225 4001 Ritchie Hwy</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8119892	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>KATHRYN (nmn) SHIPLEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 26, 1981</b>			2b. HOUR <b>10:03 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 8, 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>CROWNSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRFIELD NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Severna Pk.</b>		13c. STREET ADDRESS <b>103 Riggs Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Wigley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice M. Lee</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220.44.8817</b>		17. INFORMANT (Daughter) ADDRESS <b>101 Riggs Ave. Mrs. Mary Lee Burbage, Severna Pk, MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA - Rt Hemiplegia + aphasia</b> <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes M</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>years</b> <b>"</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>ACVD - Sick Sinus Syndrome + artificial pacemaker</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>8-22-81</b> to <b>8-26-81</b> , that (I) <del>was</del> last saw the deceased alive on <b>8-26-81</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) not view the body after death.											
22b. SIGNATURE <b>Frank Shipley M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-26-81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F.M. SHIPLEY</b>				22e. ADDRESS <b>Annapolis, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>AUG. 29, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELKRIDGE, HOWARD, MD.</b>					
24. FUNERAL DIRECTOR NAME <b>G. Easter</b> ADDRESS <b>GLEN BURNIE MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Sharon Van Nuth...</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR <i>LILLIAN B</i>		REG. NO. <i>8119893</i>								
1. DECEASED NAME (TYPE OR PRINT) <i>LILLIAN B SKEATH</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>8/11/81</i>			2b. HOUR <i>1 A.M.</i>		
3 SEX <i>F</i>		4 RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2-18-02</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (COUNTRY) <i>Pa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>AA Co.</i>				
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>N.A.C.C.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Club</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>		
13a. STATE <i>Md</i>					13b. COUNTY <i>AA</i>		13c. CITY OR TOWN <i>Severna Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Mac Adam</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Rivera Went</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>173-10-1684A-</i>		17. INFORMANT ADDRESS <i>Marvin A. Skeath - Above</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myotrophic lateral sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Parkinson's Disease</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3320</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Decubiti's</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 27</i> 19 <i>81</i> to <i>August 11</i> 19 <i>81</i> that (I) (we) lost saw the deceased alive on <i>August 10</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Mustafa Cam</i>		DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-11-81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MUSTAFA C. OZ MD</i>				22e. ADDRESS <i>605 B &amp; A Blvd Severna Park Md</i>						
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>8-14-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Highland Mem Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore High Pa</i>				
24. FUNERAL DIRECTOR NAME <i>Robert S. Baranco</i>				ADDRESS <i>Severna Park</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 14 1981</i>		REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>		

UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON

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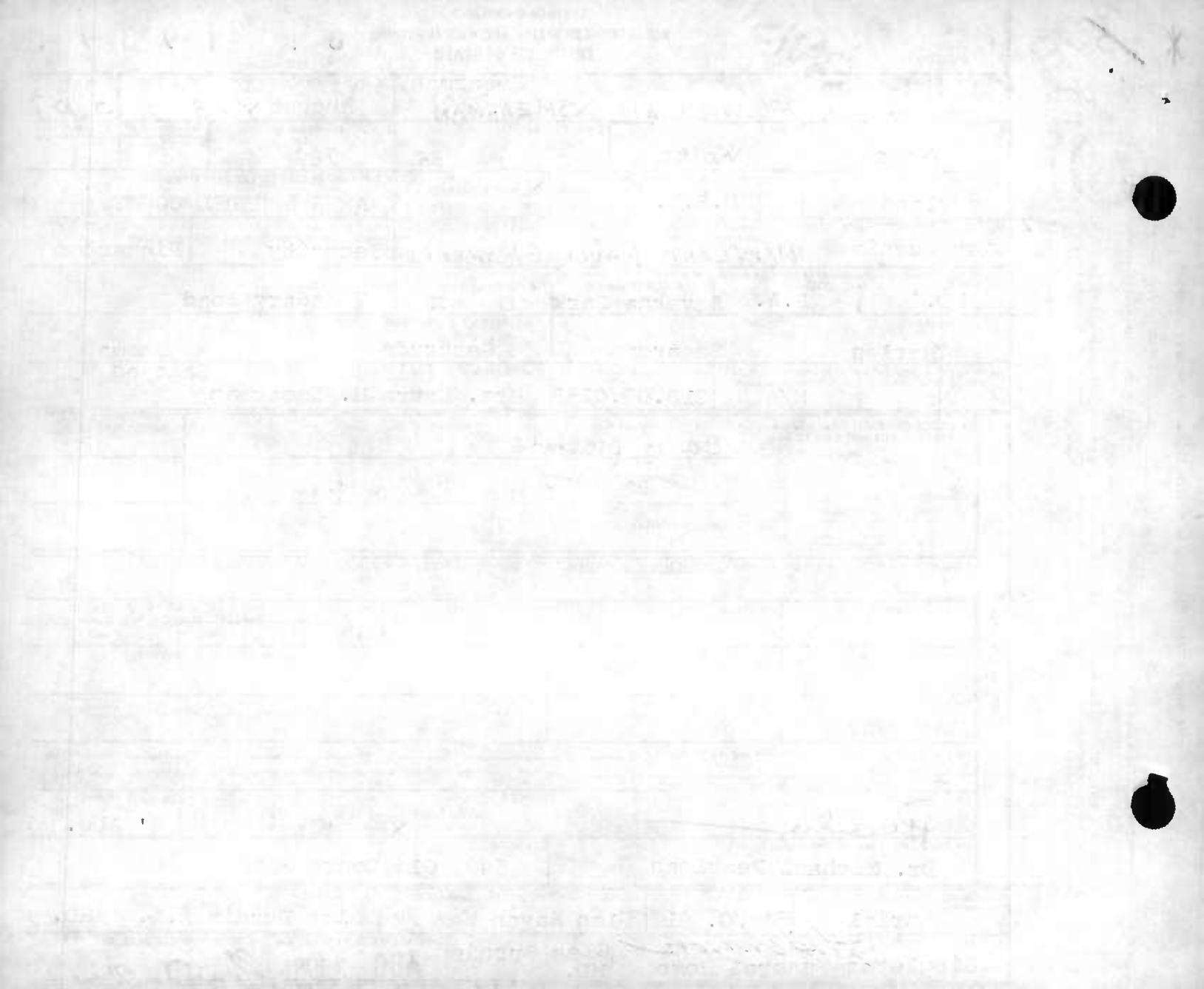
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
William Joseph		SMearman		August 3, 1981		5:10 A			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male		White		May 1 05		76 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				ANNE ARUNDEL COUNTY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Glen Burnie		MARYLAND MANOR - E HOWARD RD		Security		Pinkerton			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
MD.		A.A.		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7 Madary Road	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT (Wife) ADDRESS	
Charles		Gertrude		No		215.09.0263		Same as # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		18a IMMEDIATE CAUSE (a)		18b DUE TO, OR AS A CONSEQUENCE OF		18c DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1850		Ca of prostate		BONE Ca. metas.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION					
WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in [my] (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		DEGREE		22c DATE SIGNED			
		Dr. Michael Pearlman				3' AUG. 81			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Dr. Michael Pearlman		5400 Old Court Road							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial		5'AUG. 81		Glen Haven Mem Pk		Glen Burnie A.A. MD.			
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Singleton Funeral Home		MD.		AUG 3 1981					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Eugene Clifford Smith					2a. DATE OF DEATH MONTH DAY YEAR August 14, 1981					2b. HOUR 11:12 PM
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 2 1928		6. AGE (IN YEARS LAST BIRTHDAY) 53		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.				
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION North Arundel Hospital				12a. USUAL OCCUPATION (IF NOT WORK FOR 15 DAYS WORKING LIFE) Mech. Eng.		12b. KIND OF BUSINESS OR INDUSTRY Lab.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.					13b. COUNTY A.A.		13c. CITY OR TOWN Severna Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Clifford Isaac Smith					15. MOTHER'S MAIDEN NAME Frances Helen Reiff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Sidney Robinson Springfield Va. (Brother in law)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Donald H. Hislop					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/15/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald H. Hislop					22e. ADDRESS 1887 Ritchie Hwy., Severna Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 19 AUG '81		23c. NAME OF CEMETERY OR CREMATORY Shadowlawn Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE LaGrange Troup Co. GA.		
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD.					25a. DATE REC'D. BY REGISTRAR AUG 17 1981			25b. REGISTRAR'S SIGNATURE [Signature]		

BP

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THE  
STATE OF  
NEW YORK  
IN SENATE  
JANUARY 10, 1901  
REPORT  
OF THE  
COMMISSIONER OF  
THE LAND OFFICE  
IN RESPONSE TO  
A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899  
AND  
CONFIRMED BY THE SENATE  
MAY 1, 1900

ALBANY:  
J. B. LIPPINCOTT & CO.,  
PRINTERS,  
1899.

NEW YORK:  
J. B. LIPPINCOTT & CO.,  
PRINTERS,  
1899.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

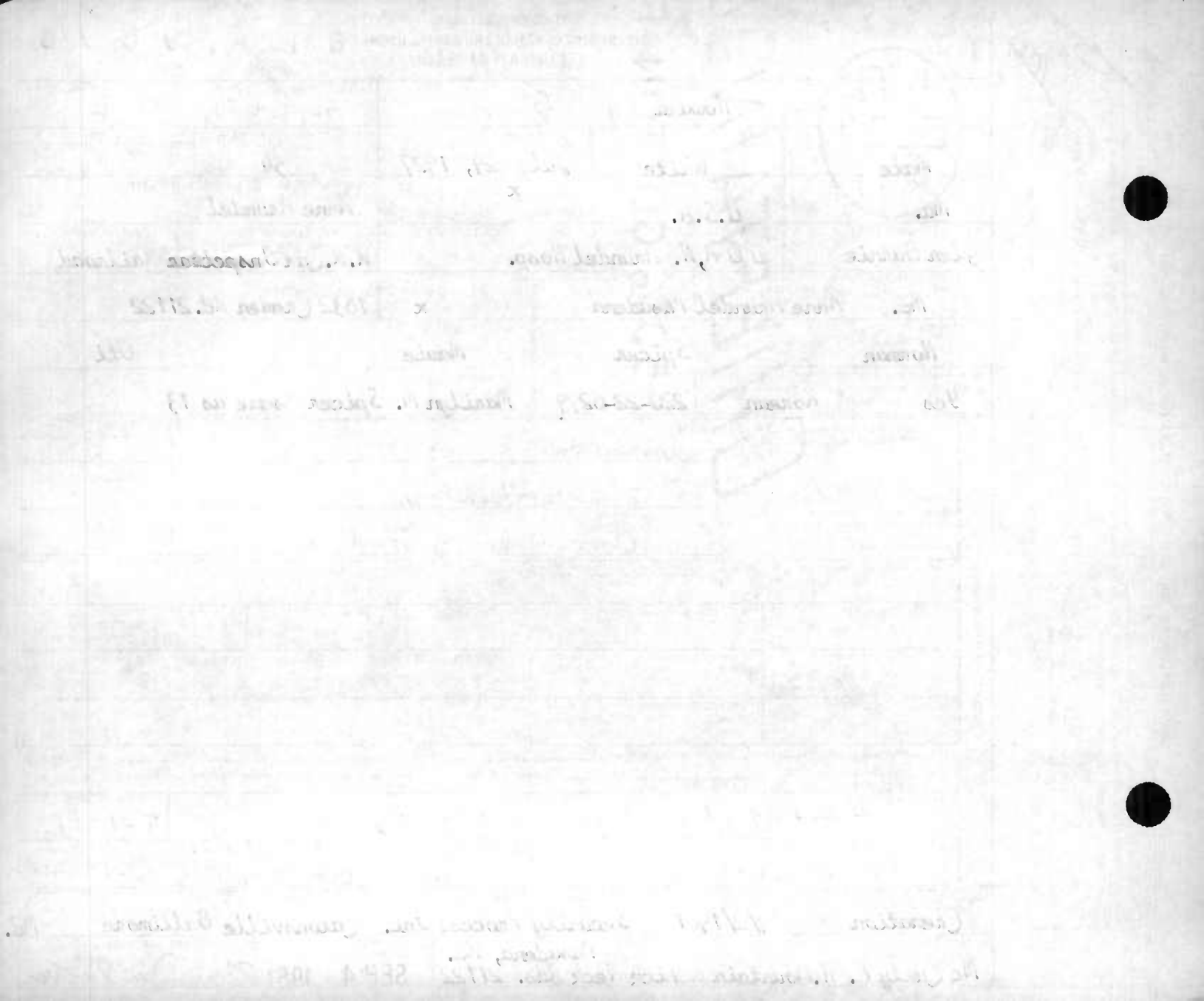
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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DHMH-16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 1 1 9 8 9 6					
1. DECEASED NAME (TYPE OR PRINT)					2b. DATE OF DEATH MONTH DAY YEAR					
James Howard Spicer					August 31, 1981					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7b. HOUR		
Male		White		MONTH DAY YEAR July 29, 1927		54 YRS.		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.		U.S.A.				Anne Arundel MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie		D.O.A.N. Arundel Hosp.				R.R. Car Inspector		Railroad		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.					Anne Arundel		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Norman Spicer					Mamie Ott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes			Korean		220-22-6279 Marilyn M. Spicer same as 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown</u> 2500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) <u>Diabetes Mellitus</u> gave rise to immediate } cause (a), stating the } DUE TO, OR AS A CONSEQUENCE OF underlying cause last. } (c) <u>chronic renal failure.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			22c. DATE SIGNED				
David Spector			MD			9-1-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
DAVID SPECTOR			Dept. of Medicine Balto. City Hospital, Balto. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation			9/2/1981		Security Process Inc.		Catonsville Baltimore Md.			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Mc Gully F. H. Mountain & Tick Neck Rds. 21122			Pasadena, Md.			SEP 4 1981 James Van Wathen				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

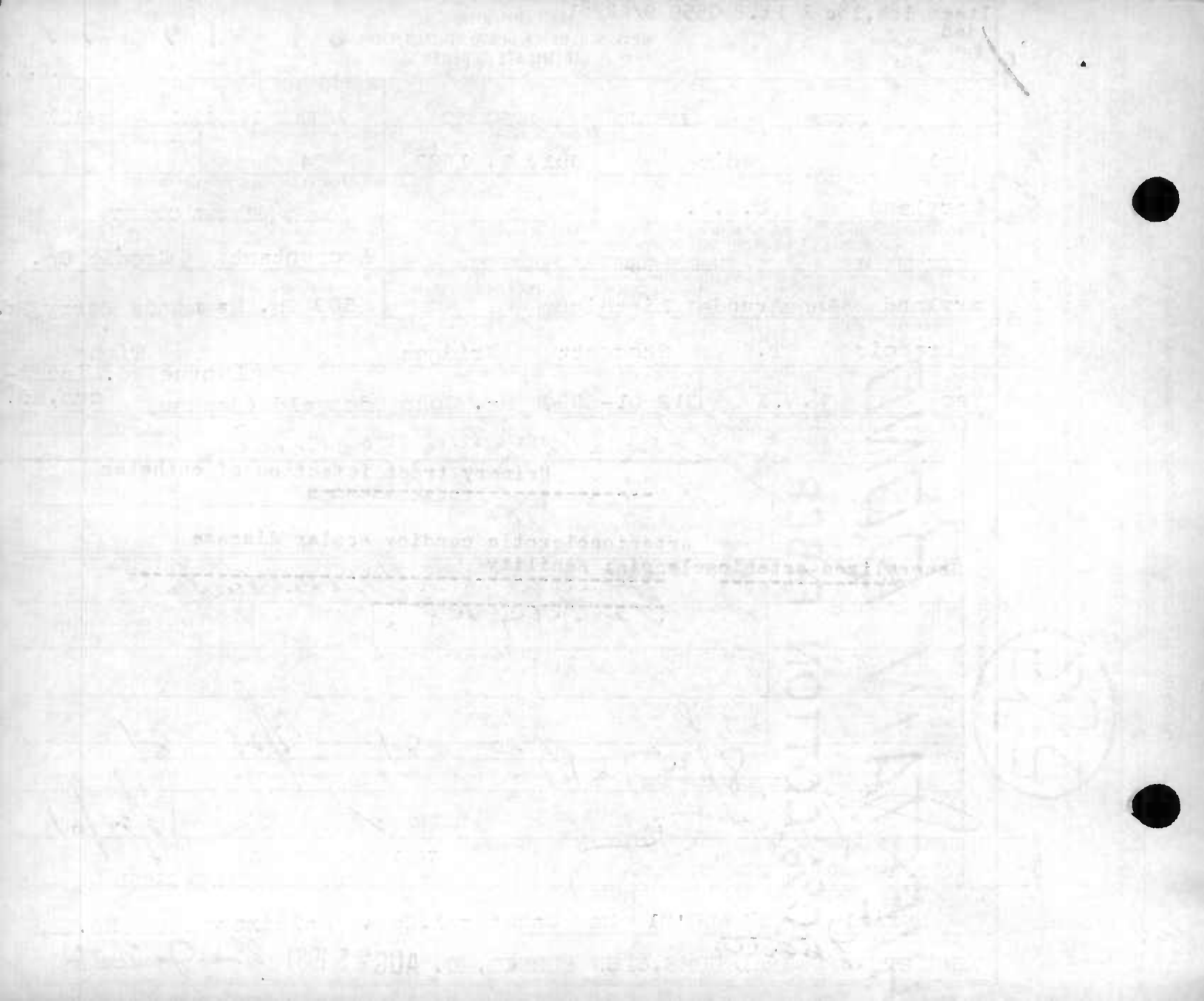
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
JOSEPH PATRICK STOCKETT		AUGUST 24, 1981		9:15 AM	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Male	White	July 1, 1887	94 YRS	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL	Accountant	Credit Co.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	AnneArundel	Linthicum	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	509 So. Hammonds Ferry Rd	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Francis T. Stockett	Bridget Tighe		Yes W.W.I.		
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
212-01-6894		Mr. John Odenwald (nephew) cum, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary tract infection of catheter</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis and arteriosclerosis</u> RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART II (d) <u>Arteriosclerotic cardiovascular disease</u>					
19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased given on above (I) (we) (did) not view the body after death.					
22b. SIGNATURE DEGREE					
22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					
23b. DATE					
23c. NAME OF CEMETERY OR CREMATORY					
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR					
25a. DATE REC'D. BY REGISTRAR					
25b. REGISTRAR'S SIGNATURE					

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>William D. Suggs Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 6 81</b>				2b. HOUR <b>12:30 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 8 27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD.</b>							
10. CITY OR TOWN OF DEATH <b>Crownsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crownsville Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shipping Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Md.</b>						13b. COUNTY <b>A.A.Co.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Suggs</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Wise</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-14-2914</b>		17. INFORMANT ADDRESS <b>Carol A. Powell 5907 Laclede Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1509 Cardio-Pulmonary Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the Esophagus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastasized</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>  <b>3 months</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (Amputation) <b>Multiple embolism of the brain and gangrene of right leg and AK</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>8-6</b> <b>81</b> to <b>8-6</b> <b>81</b> , that (I) (we) last saw the deceased alive on <b>8-6</b> <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Nureddin Erk M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nureddin Erk M.D.</b>				22e. ADDRESS <b>M.D. Crownsville Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/10/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>					
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>						ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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1. The Commission of the European Communities (CEC) has been established by the Treaty of Rome, which entered into force on 1 January 1973. The CEC is responsible for the implementation of the common policies of the Community, particularly in the fields of agriculture, transport, and research and development.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 8 9 9

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eva A. Sunderland</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-16-81</b>		2b. HOUR <b>10<sup>38</sup> PM</b>
3. SEX <b>female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.		
10. CITY OR TOWN OF DEATH <b>Annapolis</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR <b>Merchandise Store.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Anne</b> 13c. CITY OR TOWN <b>Deale</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>510 Deale Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Russell H. Anderson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl Bassford Anderson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT ADDRESS <b>510 Deale Rd. Leroy P. Sunderland-Deale, Md 20751</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Heart Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3<sup>th</sup> hr</b> <b>4 hrs</b> <b>10 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>---</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-15-1972</b> to <b>8-16-1981</b> , that (we) last saw the deceased alive on <b>8-14-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.					
22b. SIGNATURE <b>Frank Shipley, M.D.</b>				22c. DATE SIGNED <b>8.17.81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FM Shipley, M.D.</b>				22e. ADDRESS <b>121 Cathedral Avenue Annapolis, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood (P.G.) Md.</b>					
24. FUNERAL DIRECTOR <b>Richard A. Coleman - Upper Marlboro, Funeral Home Maryland 20870:</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2  
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL EXAMINER NOTIFIED 8/25/81

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 9 0 0			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert Leonard Swanson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 25, 1981</b>		2b. HOUR <b>6:45</b> A. M.	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 22, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Univ. of Maryland</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne</b>		13c. CITY OR TOWN <b>Lothian</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl Leonard Swanson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily -- Petschelt</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>Margot P. Swanson-145 First St., Lothian, Md. 20721</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 3960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Severe Heart failure</b> (c) <b>Aortic &amp; Mitral Valve Disease</b> 2 YRS. 2 YRS. 6 YRS.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Aortic &amp; Mitral Valve Prolapses</b>							
19a. DATE OF OPERATION <b>2/81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aortic &amp; Mitral Valve Disease</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/20</b> , 19 <b>81</b> , to <b>August 25</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>7/20</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>D. K. Joshi</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/26/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. K. Joshi, M.D.</b>				22e. ADDRESS <b>6525 Belcrest Road Hyattsville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8/26/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland (Pr. Geo's) Md.</b>	
24. FUNERAL DIRECTOR <b>Richard A. Coleman - Upper Marlboro, Funeral Home Maryland 20870:</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Nathan</b>	

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Vertical text on the right margin, possibly a date or reference number.

Top section of text, including names and dates, possibly a header or address block.

Middle section of text, appearing to be a list or a series of entries.

Large central section of text, possibly a main body or a detailed list.

Bottom section of text, including names and dates, possibly a footer or a concluding block.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

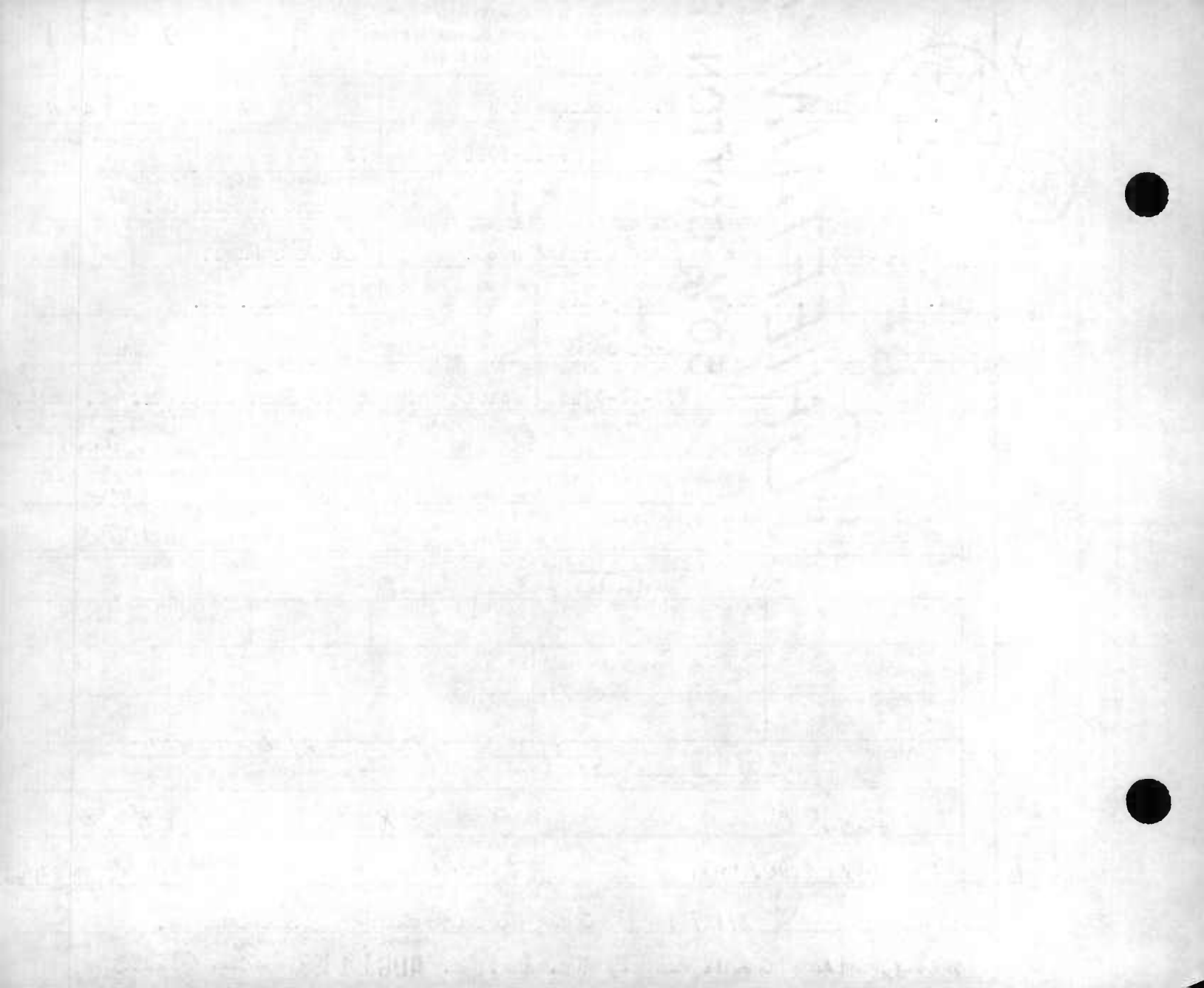
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 9 9 0 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter L. Swieczowski				2a. DATE OF DEATH MONTH DAY YEAR 8 10 81		2b. HOUR 2 11 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9-26-1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret News Paper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Swieczowski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josphine Korda					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 212-26-3225		17. INFORMANT ADDRESS Dorothy Howell 900 Swan Creek Rd. Ft. Wash.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/49 Shunt DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic heart disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year 1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive pulmonary disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/1 19 81, to 8/10 19 81, that (I) (we) last saw the deceased alive on 8/9 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE General Chunch		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERMAN CHUNCH		22e. ADDRESS 8 EVANGELIST LANE SEWANA PARK MD 21146					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/12/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.				25a. DATE REC'D. BY REGISTRAR AUG 14 1981			
				25b. REGISTRAR'S SIGNATURE Anne J. [Signature]			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 9 0 2	
1- FOR STATE REGISTRAR		REG. NO.								EDT	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD DEVEREAUX THOMAS, SR						2a. DATE OF DEATH MONTH DAY YEAR AUGUST 29, 1981				2b. HOUR 8:12 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 21 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
12. CITY OR TOWN OF DEATH GLEN BURNIE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO. PAINTER		15. KIND OF BUSINESS OR INDUSTRY CHEESAPEAKE CAD			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MARYLAND 16b. COUNTY ANNE ARUNDEL 16c. CITY OR TOWN PASADENA						17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS 8243 ANNAPOLIS BLVD.			
19. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ALFRED THOMAS, SR						20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA UNKNOWN					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		22. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		23. INFORMANT PEARL L. THOMAS		24. ADDRESS (SAME AS 13)					
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASCD</u>										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED				28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET CITY OR TOWN COUNTY STATE							
36. I certify that (a) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>81</u> , to <u>8-29</u> , 19 <u>81</u> , that (we) lost saw the deceased alive on <u>8-29</u> , 19 <u>81</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (do not) view the body after death.											
37. SIGNATURE <u>Robert B. Kroopnick</u>						38. DEGREE M.D.		39. MEDICAL STAFF ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		40. DATE SIGNED 8/28/81	
41. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KROOPNICK, M.D.						42. ADDRESS 205 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061					
43. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		44. DATE 9-1-81		45. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		46. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE HOWARD MD.		47. DATE REC'D. BY REGISTRAR SEP 0 1 1981			
48. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO 501 RITCHIE HWY. SEVERNA PARK, MD.											

BP

UNITED STATES  
NAVY  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C. 20340

MEMORANDUM FOR THE SECRETARY  
SUBJECT: [Illegible]  
DATE: [Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 9 0 3

FOR STATE REGISTRAR		REG. NO.		EDT	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH THOMAS			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 11, 1981		2b. HOUR 7:45 P.M.
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR JUNE 30 1927		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN) RIPON, WVA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROOM		12b. KIND OF BUSINESS OR INDUSTRY TRAINING-HORSE
13a. STATE WVA		13b. CITY OR TOWN RIPON	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS RURAL
14. FATHER'S NAME FIRST MIDDLE LAST FRANK M. THOMAS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE PAYNE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN		16b. SOCIAL SECURITY NO. 233-44-7384		17. INFORMANT ADDRESS ROSEITA THOMAS RIPON, WVA 25414	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis, Metabolic DUE TO, OR AS A CONSEQUENCE OF (c) Encephalopathy					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pneumonia Patient stopped Eating					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-9, 19 81, to 8-11, 19 81, that (I) (we) last saw the deceased alive on 8-11, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward N. Sherman		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-12-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD N. SHERMAN, M.D.		22e. ADDRESS 205 BALTIMORE ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL BY BURIAL	23b. DATE 8-14-81	23c. NAME OF CEMETERY OR CREMATORY MARSTOWN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE MARSTOWN JEFFERSON WVA	
24. FUNERAL DIRECTOR NAME SLACK Funeral Home		ADDRESS P.O. Box 266 EMICOTT CITY MD 21043		25a. DATE REC'D. BY REGISTRAR AUG 18 1981	
				25b. REGISTRAR'S SIGNATURE Anne J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 9 9 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Franciszek Trocki Trocke</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 24 81</b>			2b. HOUR <b>8:45</b> AM	
3. SEX <b>m</b>		4. RACE <b>w</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 10 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.	
10. CITY OR TOWN OF DEATH <b>Crofton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Crofton Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Longshoreman</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>md.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>2222 Lake Drive</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franciszek - Trocke</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary LESZYNSKI</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>215-09-3357</b>		17. INFORMANT ADDRESS <b>Crofton Conv. Center RT 424 P. Reisterstown</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>cardiomegaly of a lung with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3/27 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>3/27 81 P1</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/24 81</b> to <b>8/24 81</b> , that (I) (we) lost saw the deceased alive on <b>8/24 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Max Frank</b>		DEGREE <b>MD</b>				22c. DATE SIGNED <b>8/24/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAX FRANK</b>		22e. ADDRESS <b>7575 Ritchie Hwy Glen Burnie</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>8 27 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZUROWSKI</b>		24b. ADDRESS <b>2525 FLEET ST</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Frances Santhorne</b>	

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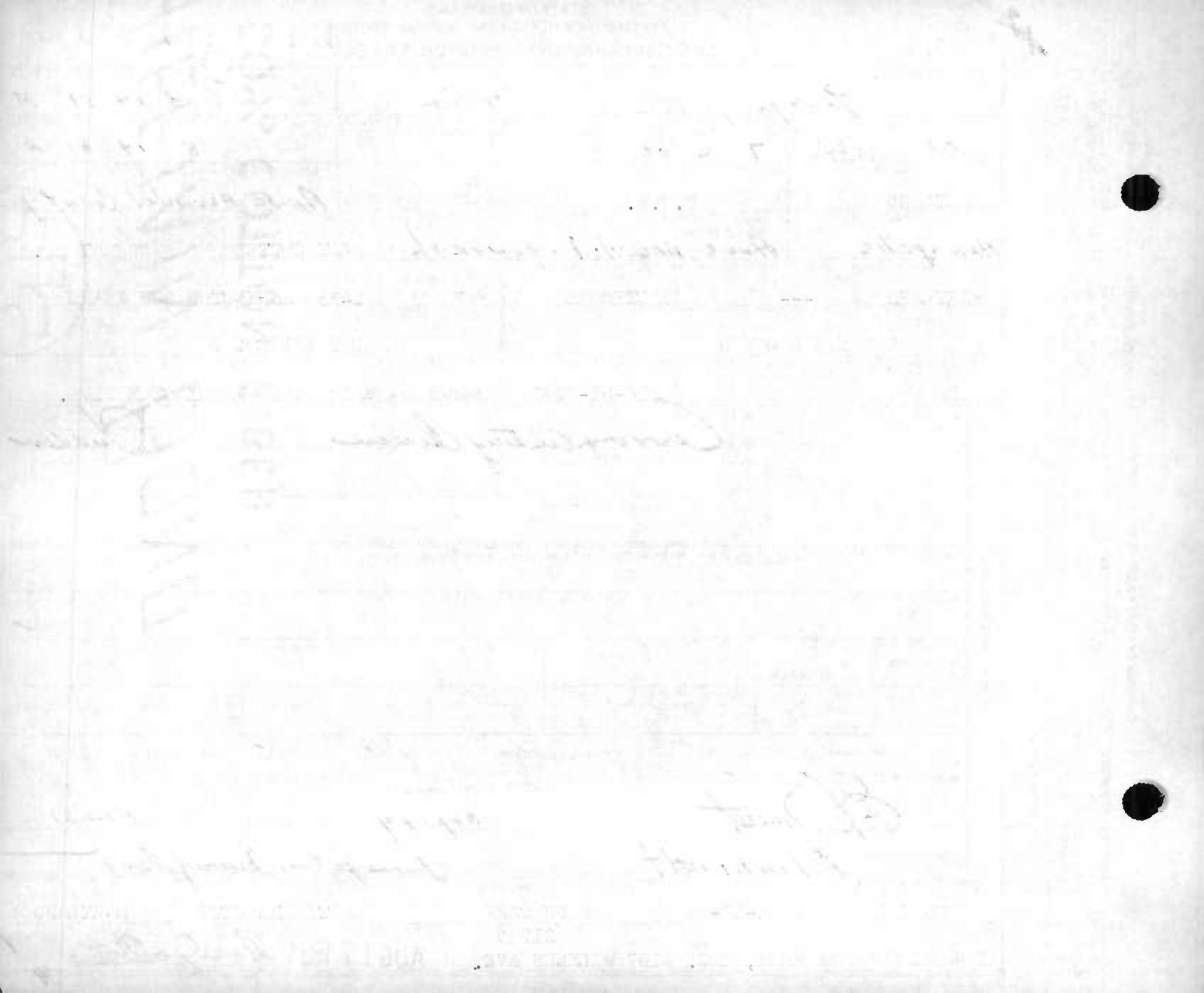


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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19905	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE ALVIN VAIN</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>8 14 19 81</b>		2b. HOUR <b>11 A</b>			
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>07</b> DAY <b>03</b> YEAR <b>08</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>8 14 19 81</b>		2d. HOUR <b>11 A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel County MD</b>					
10. CITY OR TOWN OF DEATH <b>Annapolis</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel - general</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MEAT CUTTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ESSKAY CO.</b>			
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2435 WASHINGTON BOULEVARD</b>			
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>216-01-7283</b>		17. INFORMANT ADDRESS <b>MAGDALENA VAIN 2435 WASHINGTON BLVD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery disease</b> <b>4149</b> } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linch</b>				TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>8-14-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linch</b>				ADDRESS <b>Annapolis, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>08-17-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 WILKENS AVE.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURA B VANSICKLE						2a. DATE OF DEATH MONTH DAY YEAR 8 3 - 81		2b. HOUR 7:19 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3 2 02		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10 CITY OR TOWN OF DEATH Annapolis, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md. 21401 A.A. Co						13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 22 Maryland AVE	
14 FATHER'S NAME FIRST MIDDLE LAST George Black						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cenetta Fox					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-30-8137		17 INFORMANT ADDRESS Mary Morrissetta - 3 Diddings Ave Severna Park							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-18-81 to 8-3-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I did not view the body after death.											
22b. SIGNATURE Arnold G. Alexander				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-3-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arnold G. Alexander				22e. ADDRESS Severna Park MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-4-81		23c. NAME OF CEMETERY OR CREMATORY Glenview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.					
24 FUNERAL DIRECTOR NAME Robert S. Barranco				ADDRESS 501 Richfield Ave Severna Park				25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 1981			

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Handwritten text at the top of the page, including a date "2-10-81" and other illegible markings.

Handwritten text in the middle section, possibly a list or series of notes.

Handwritten text in the lower middle section, continuing the notes or list.

Handwritten text at the bottom of the main body, including some numbers and names.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 9 9 0 8 REG. NO. E.D.T.	
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEO T. WEISINGER</b>				2a DATE OF DEATH MONTH DAY YEAR <b>AUGUST 23, 1981</b>			2b HOUR <b>2110</b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 15, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Maryland</b>			13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4800 Walther Blvd - 21214</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Weisinger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martina Spitznagel</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-10-4312</b>		17 INFORMANT ADDRESS <b>Mrs. Anna J. Brendel-4800 Walther Blvd.-21214</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic CVD, cerebral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5 yrs</b> (c) <b>Arteriosclerotic CVD, generalized</b> <b>10 yrs</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 d.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Severe arthritis, generalized</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD O. HUNT, JR., M. D.</b>			22e. ADDRESS <b>2300 Garrison Blvd - 21216</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 27, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Henry Sander &amp; Sons, Inc., Baltimore, Md.</b>			ADDRESS <b>- 21213</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 28 1981</b>			25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>		



• 54 •

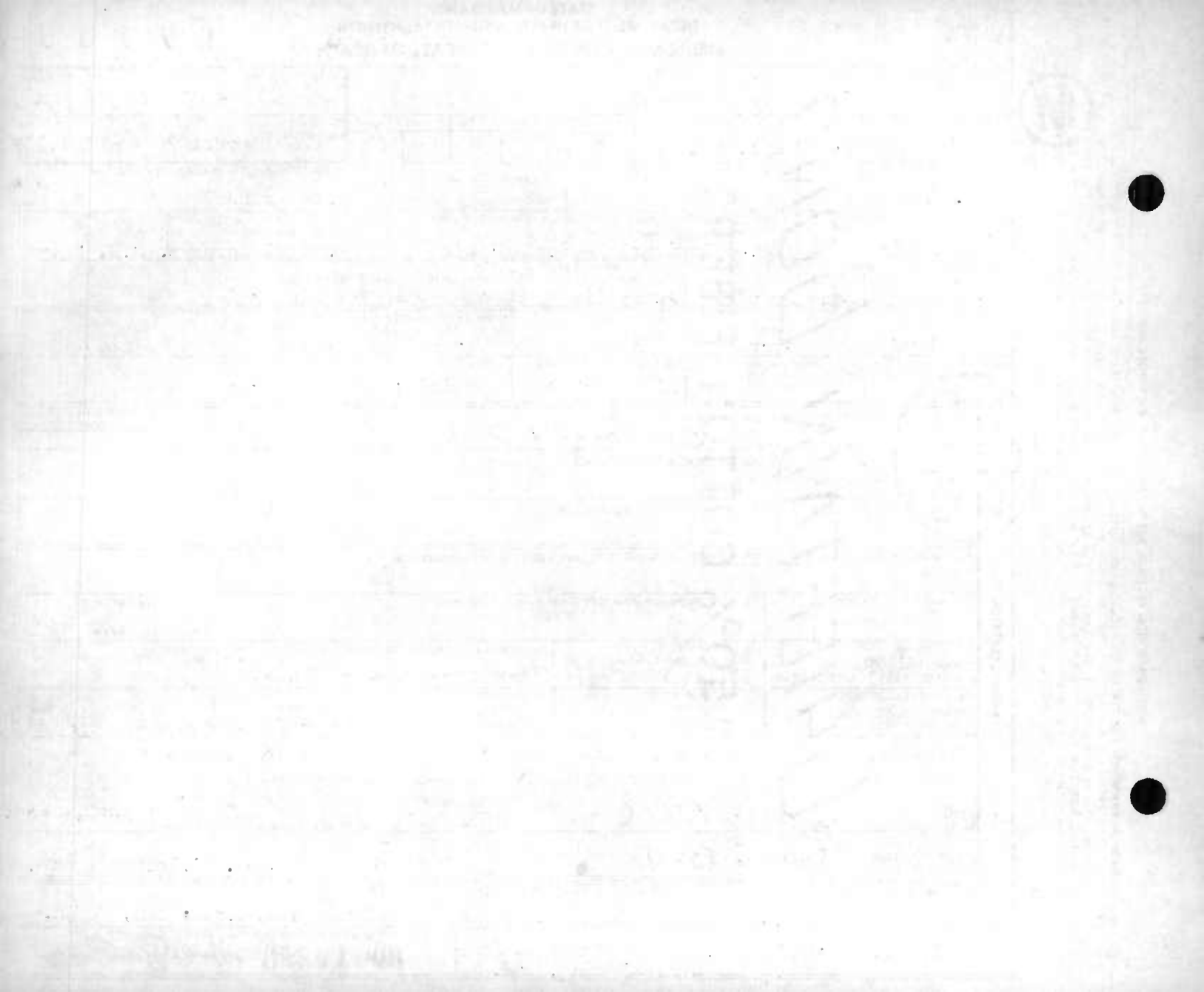
## Dealing

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19909					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John Douglas WHITE</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>8-2-81</b>		2b. HOUR <b>AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 28 1959</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>21</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>August 2 1981</b>		2d. HOUR <b>1:55 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.			
10. CITY OR TOWN OF DEATH <b>Annapolis</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Naval Regional Medical Clinic</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hospital Corpsman U.S. Navy</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Annapolis</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>108 Pine Drive</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lloyd Edward White</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Susan Agnew</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1979-81</b>		17. INFORMANT ADDRESS <b>Official Naval Records</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9505 IMMEDIATE CAUSE (a) Over dose of Drugs.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 PM 8-2-1981</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Took over dose of Drugs.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>clinic</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Naval R. Med. Clinic Annapolis Anne Arundel Md</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>3 August 1981</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G Ball</b>				ADDRESS <b>7936 Old Georgetown Rd. Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Aug. 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arlington, Va.</b>					
24. FUNERAL DIRECTOR NAME <b>W. W. Chambers Co Inc</b>										ADDRESS <b>8655 Georgia Ave Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 10 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

BP

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		81 19910 REG. NO. E.D.T.	
1. DECEASED NAME (TYPE OR PRINT) <b>CLAYTON HOWARD WILLARD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 27, 1981</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>12-11-1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ANNE ARUNDEL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>GLEN BURNIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GEN. SUPERVIS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>ANNE ARUNDEL</b>	
13c. CITY OR TOWN <b>GLEN BURNIE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>469 RIVERSIDE DRIVE</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>BENJAMIN WILLARD</b>	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OLIVE ELDRIDGE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	
16b. SOCIAL SECURITY NO. <b>216-09-2925</b>		17. INFORMANT ADDRESS <b>Dr. Frances Willard - 469 Riverside</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probable myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4100</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15-20 min</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from <b>21 Aug</b> 19 <b>81</b> , to <b>21 Aug</b> 19 <b>81</b> , that (1) <b>we</b> last saw the deceased alive on <b>21 Aug</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22a. SIGNATURE <b>Lorraine M. Dailey MD</b>		22b. ADDRESS <b>8667 FORT SMALLWOOD ROAD PASADENA MARYLAND 21122</b>	
22c. DATE SIGNED <b>8-27-81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LORRAINE DAILEY, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>8-31-81</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALTO, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wartley Miller - 7527 Hanford Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Miller</b>			

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1901-11-11

WILLARD

CLAYTON

WILLARD

U.S.A.

M. K. W.

NORTH ANNEAPOLIS HOSPITAL

CLIN. EXAMINE

Mr. Andrew Green, 1015 N. Riverside Drive, Annapolis, Md.

CLAYTON

WILLARD

W. E. Green, 1015 N. Riverside Drive, Annapolis, Md.

8667 PORT SMALLWOOD ROAD  
PASADENA MARYLAND 21122

LOCATING DAILY, N.D.

8-21-81 13:00 PM

8-21-81 13:00 PM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PIERCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19911	
1. DECEASED NAME (TYPE OR PRINT) <b>ROSMOND WILLIAMS</b>										2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 2b. HOUR <input type="checkbox"/>	
3. SEX <b>F</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>23</b> YEAR <b>1929</b> (51 <sup>yr</sup> )		6. AGE (IN YEARS) LAST BIRTHDAY <b>(51<sup>yr</sup>)</b>		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Madison, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.A.C.O.</b>		2c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>15</b> YEAR <b>1981</b>		2d. HOUR <b>P</b>	
10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH ARUNDEL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>107 Key Ave</b>			
14. FATHER'S NAME FIRST <b>Hanson</b> MIDDLE <b>Kane</b> LAST <b>Edith</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Edith</b> MIDDLE <b>Stanley</b> LAST <b>Stanley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>216 28 1687</b>		17. INFORMANT ADDRESS <b>Barbara Kane 710 Lennox St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>E. Linhardt MD</b>				TITLE (SPECIFY) M.D. <b>Depot</b>				MEDICAL EXAMINER		DATE SIGNED <b>8-15-81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt MD</b>				ADDRESS <b>Annapolis, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial</b>				23d. LOCATION CITY OR TOWN <b>Balto</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett</b> ADDRESS <b>4600 Liberty Heights Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 18 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>					

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

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(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8119912		
FOR STATE REGISTRAR			REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
June D Wilson						August 27, 1981		6:15 AM
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
FEMALE	WHITE	6 12 1916		65				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MD.				
New York	USA			Anne Heudel				
10 CITY OR TOWN OF DEATH	N. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis	Annapolis Nursing Home			Housewife		HOME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS			
MD. 13c. COUNTY ANNAPOLIS					462 FOREHANDS RD.			
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George Franklin Dodson			Thelma White Turner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
NO			124-12-5518		Sally D. McGee Annapolis, Md. 451 WAGGAMON Circle			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism 4151 } DUE TO, OR AS A CONSEQUENCE OF (b) Unknown. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebrovascular dysfunction - earlier stroke								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21g. I certify that (I) (this hospital) attended the deceased from [date] 8/26/81 to [date] 8/27/81, that [we] (we) last saw the deceased alive on [date] 8/26/81 and that in [my] (our) opinion death occurred on the date and hour and from the causes stated above.		22a. SIGNATURE DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS						
Peter F. Verkoren MD		1419 Forest Drive Annapolis, Md. 21408						
23a. BURIAL, CREMATION, REMOVAL (CHECK)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		8/28/81		F. Lincoln		Beentwood PG. MD.		
24. FUNERAL DIRECTOR (NAME)		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John M. L. Laxton		Annapolis, Md.		AUG 31 1981		[Signature]		

*[Faint, illegible handwriting on lined paper, possibly bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]*

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M 2/BO

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 19913		
1. DECEASED NAME (TYPE OR PRINT) <b>Evie L. Virginia Wise</b>										2a. DATE KNOWN OF DEATH MONTH <b>8</b> DAY <b>19</b> YEAR <b>1981</b>		2b. HOUR <b>AM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>4</b> YEAR <b>23</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>57</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>19</b> YEAR <b>1981</b>	2d. HOUR <b>AM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>B. A. Co.</b>						
10. CITY OR TOWN OF DEATH <b>glen Burnie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North Arundel Hosp. 72 L</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>187 Southwood Rd. 21122</b>				
14. FATHER'S NAME (FIRST) <b>Edward</b> (MIDDLE) <b>Platter, Sr.</b> (LAST) <b>Wise</b>				15. MOTHER'S MAIDEN NAME (FIRST) <b>Velma</b> (MIDDLE) <b>Grooves</b> (LAST) <b>Grooves</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-16-4239</b>		17. INFORMANT <b>Henry J. Wise</b>		ADDRESS <b>Same as #13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>Thrombotic Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) <b>M.D. Depo 49</b>				MEDICAL EXAMINER <b>[Signature]</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>E. L. Winkler</b>				ADDRESS <b>[Signature]</b>				DATE SIGNED <b>8.19.81</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8/22/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc.</b>		23d. LOCATION CITY OR TOWN <b>Catonsville, Balto., Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>AUG 21 1981</b>				
24. FUNERAL DIRECTOR NAME <b>Mc Cully F.H. Mtn. &amp; Tick Neck Rds., Pasadena, Md.</b> ADDRESS <b>21122</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>								



10/1/2015